DOCUMENT RESUME

ED 375 338 CG 025 599

AUTHOR Utesch, William E.
TITLE A Comparison of Clinical and Non-Clinical Samples Using the Concepts of: Individual Personality, Family Structure, Family of Origin Perception, Sexuality, and Adjustment/Adaptability To Determine Family Risk for Father Daughter Incest.
PUB DATE [89]
NOTE 117p.; Doctoral Thesis, Purdue University.
PUB TYPE Dissertations/Theses - Doctoral Dissertations (041) -- Tests/Evaluation Instruments (160)

EDRS PRICE MF01/PC05 Plus Postage.
DESCRIPTORS Child Abuse; Child Behavior; *Daughters; Family (Sociological Unit); Family Environment; *Family Problems; *Family Structure; *Fathers; *Incest; Parent Child Relationship; Personality Studies; Rape; Self Concept; *Sexual Abuse; Sexuality
IDENTIFIERS *Family of Origin

ABSTRACT

Father-daughter incest is more traumatic than any other type of child-sexual molestation. This study examines some of the factors which may lead to father-daughter incest. The author divided 40 Caucasian couples into three groups: (1) clinical incest group; (2) clinical non-incest group (to control for clinical status); and (3) non-clinical group. Each couple answered a series of self-reporting questionnaires along with other information forms. The researcher examined 12 variables and correlated the results between the three test groups using a variety of statistical measures. When compared to the non-clinical groups, the clinical incest and clinical non-incest groups exhibited higher cross-generational triads, more father-child estrangements, more expressions of family conflict, and higher parent-child autonomy. Family members appeared distant and disconnected from one another and, as is typical in these kinds of families, children often moved inappropriately into an adult role by default, resulting in the children parenting themselves and their own parent(s). The researcher did not find any significant differences between the clinical-incest group and the clinical non-incest group. One possible explanation for this lack of significant differences could be that the 2 groups resemble each other on the 12 variables tested. (RJM)

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ED 375 338

A COMPARISON OF CLINICAL AND NON-CLINICAL SAMPLES USING THE CONCEPTS OF; INDIVIDUAL PERSONALITY, FAMILY STRUCTURE, FAMILY OF ORIGIN PERCEPTION, SEXUALITY, AND ADJUSTMENT/ADAPTABILITY TO DETERMINE FAMILY RISK FOR FATHER DAUGHTER INCEST

A Doctoral Thesis Submitted to Purdue University by

William E. Utesch, Ph.D.

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ABSTRACT

Utesch, William Edward, Ph.D., Purdue University, August 1989. "A Comparison of Clinical and Non-Clinical Samples Using the Concepts of: Individual Personality, Family Structure, Family of Origin Perception, Sexuality, and Adjustment/Adaptability to Determine Family Risk for Father-Daughter Incest." Major Professor: Doug Sprenkle, Ph.D.

This Study addresses the viability of the correlates of father-daughter incest put forth in the literature to-date. Previous explanations and factors were integrated into a model of family vulnerability and offender potential.

A sample of eighty individuals (forty couples) was divided into three groups: clinical incest, clinical non-incest, and non-clinical. Twelve variables were tested to determine group membership: sexuality, family of origin perception, adaptation/adjustment, personality, enmeshment/disengagement, father-child cohesion/estrangement, mother-child cohesion/estrangement, cross-generational coalitions, spouse conflict resolved/unresolved, family conflict avoided/expressed, flexibility/rigidity, and over-protection/autonomy.

Five self-report instruments were given to each individual: The Family of Origin Scale, The SFIS-R, The FIRA-G, The Eysenck Personality Short Questionnaire, and the HCSQ.

Chapter I

Introduction

Statement of the Problem

Taboos concerning the sexual abuse of children have existed for centuries, (as has the abuse) in both primitive and modern cultures (Wulkan & Bulkley, 1985). It is the very existence of this strong taboo that identifies the intense emotional reaction of many to such an act against children.

Father-daughter incest accounts for 62% of sexual abuse cases known to clinicians (Trepper & Barrett, 1986). Prevalence studies agree that though father-daughter incest may be the most reported it is not the most prevalent. There is some disagreement over whether uncle or sibling molest occurs more frequently (Russell, 1986).

Father-daughter incest has been found to be more traumatic than any other type of child-sexual molestation (Russell, 1986). Henry Giarretto of the California Sexual Abuse Treatment Program (1976) states: "Father/daughter incest is the type most commonly reported to authorities. Perhaps for this reason, it is the type most commonly studied and about which most is known."

A closer look at this supposedly well-trodden ground by psychologist Karin Meiselman (1978) determined that only thirty-six studies of incest met her criteria of; (1) sample size larger than five, and (2) publication in this

country before 1977. Studies conducted since Meiselman published her analysis have been equally unrepresentative and not generalizable to a larger population (Russell, 1986).

Even though father-daughter incest is the type "most commonly studied" and "about which most is known", it is clear that very little research validation has actually been accomplished, leaving much of what we "know" still questionable.

Significance of the Problem

The study of father-daughter incest is a difficult one. Child sexual abuse, including father-daughter incest, did not move to the forefront of societal concern until the late 1970's. Data collection on a national level did not start until 1976. This was initiated by public child protection agencies. Before data collection began on a more sophisticated level, Child molestation was considered rare, before sophisticated data collection began, in spite of prevalence studies dating back to 1929 (Finkelhor, 1986). Since data collection on a national level began in 1976, the number of substantiated cases of child sexual abuse has nearly doubled each year. Current estimates suggest that when all types of incest are included in the final total, more than a quarter million children are victimized annually in the United States. It is estimated that one out of every five females and one out of every eleven males are sexually victimized during childhood, usually by family members (Finkelhor,1987).

Russell's study of urban women revealed that child sexual abuse prevalence was greater than previously believed and cuts across all social and economic boundaries (Russell, 1985).

Ninety percent of all child molesters are someone a child loves and trusts; ten percent are strangers. Fifty percent of that ninety percent are fathers and stepfathers. Thirty percent are brothers, uncles, grandfathers, and cousins. Ten percent are known but not related (Sgroi, 1982; Finkelhor, 1979).

Clinical interest has been noted as early as the publication of a collection of incest histories in 1886 (Krafft-Ebing, 1886). In the 1920's and 1930's, Freud encountered many woman in psychoanalysis who were identifying incestuous victimization when they were children. These were identified by him as fantasies and their accounts discredited (Freud, 1933).

Benjamin Schlesinger (1982 & 1986) reviewed 55 different journals & books published in the United States and Canada (nearly 500 articles) addressing child sexual abuse from 1937 to 1980. A wide variety of disciplines were represented because of the broad sources utilized to obtain the information: The National Institute of Mental Health, Department of Health and Human Services, the Sexual Assault Center, Harborview Medical Center in Seattle, Washington, and various schools of social work. Schlesinger found that from 1937 to 1964 only one article per year was found and from 1965 to 1976 the mean number

of articles found per year was 3! It was not until 1977 that the annual number rises to 13 with a mean number of 18 articles per year from 1977 to 1985.

As a result of improved data collection methods, the significance of child sexual molest has been made a reality in the awareness of many. The number of treatment programs for sexual molest has grown in the U.S. from 20 in 1976, to 300 in 1984 (Bulkley, 1985).

It is generally accepted that many incidents of incest are not reported, and little consensus exists among social scientists about the actual magnitude of this problem. The very nature of the problem, its secrecy, shame, and the criminal sanctions against it, make it difficult to identify. There is agreement on one major point however: the scope of the problem as current figures suggest, the actual incidence and prevalence is underestimated (Finklhor, 1986).

Problems With Past Research

Greer (1983) summarizes the lack of attention given to incest:

> "Despite ample documentation that children have been sexually exploited by adults throughout history, that childhood sexual experiences are so widespread as to be considered virtually universal by some researchers (Finkelhor, 1978), and that the problem has been reported and discussed in professional literature since the turn of the century (Finkelhor, 1980), society has been slow to respond with any systematic

efforts to prevent or treat it."

Finklhor (1986) provides two possible reasons for this slow response. First, sexual abuse has not fallen clearly into a particular discipline's domain. For this reason, many studies have been overlooked due to poor communication between disciplines. Also, child-sexual abuse is in the category of social relationships, an area not prioritized in government-sponsored research.

Outcome research is in its infancy in the specialized area of intrafamilial child sexual abuse. The scant data available, mostly surveys and anecdotal accounts, are open to the criticisms of memory deficit and subjective distortion inherent in retrospective studies. As Swift (1977) concludes: "Disagreement over the definition of sexual abuse, methodological problems involved in observing and measuring private events and societal taboos complicate scientific attempts to explore the subject."

The problems for researchers have been many and varied, the most fundamental have been a lack of knowledge of the true prevalence of this problem and the characteristics of the people involved. Those interested in incest have had to resort to small samples, usually made up of selected individuals such as prisoners and those currently in treatment. Ethical concerns restrict the use of control groups and limit most studies to retrospective designs and case studies. Finally there is the extreme difficulty of separating out the antecedent-conditions, correlates and effects of molestation

(Finkelhor, Gelles, Hotaling, Strauss, 1983).

Purpose of this Study

This study will examine correlates of father-daughter incest. The model presented takes into account related factors that are commonly espoused in incest literature. It will include the explanatory models given to date for father-daughter incest.

This model views incest as interacting with, rather than the cause of a problematic family system, and proposes to identify multiple individual, familial, and extra-familial factors which contribute to the development of incest. It is a model of vulnerability as defined by Trepper & Barrett (1986); " There is no single cause of intrafamily sexual abuse. Instead, all families are endowed with a degree of vulnerability based on individual, family, and environmental factors, which may express as incest if a precipitating event takes place and the family's coping skills are low."

This study is also a model of offender potentiality, taking into account the factors in the life of the offender that result in a higher potential for him to choose molest in a family of high vulnerability. This potential includes factors of individual personality, the way he responds to stressor pile-up, his own experience with sexuality and relationships, and his belief about his personal worth and the worth of women and children.

The current feminist critique of family therapy for incest aptly points out the importance of noting the role

of socialization in the treatment of incest. Men in this patriarchal society have been socialized and supported in an objectification of women and children with women and children being socialized and supported to respond complimentarily as victims (Mayer, 1983). This critique emphasizes an awareness of the socialization perception in the treatment process. Family therapy includes all family members in the assessment and treatment process and must be cautioned that a family does not perceive this as blaming a mother and victim.

A mother, victim, and siblings must be educated not only in offender factors that contributed to a father's choice to molest, but also in the factors relating to the family and its members that will strengthen them and resocialize them for the future. Care should be taken in presenting this information that its purpose is not to show responsibility for incest but to identify areas that have been vulnerable and need strengthening. To not provide this comprehensive understanding would be to continue their victimization and withhold that which will make them stronger.

It is not the intent of this study to remove responsibility from the male molester. It is an attempt to specify that which can be attributed to the offender and to intrafamilial & extrafamilial components for the purpose of improving assessment and comprehensive treatment interventions.

Theory Integration

Research guided by theory is needed to hold accountable the many assumptions that exist concerning father-daughter incest. Concise reasoning that builds theoretically from conceptualization to more testable hypotheses is required to design analyses that will render meaningful results.

The integration of Symbolic Interactionism, General Systems, and Family Stress theories allows a lens through which to view father-daughter incest. Through this lens, the many correlates of this type of incest are subsumed with a rationale for their interplay and contribution to this complex phenomena. It is this rationale that has guided my research design.

The proposed model is an integration of four conceptual frameworks: (1) Symbolic-Interaction. "The family is a unity of interacting persons, each occupying positions within the family to which a number of roles are assigned, i.e., the individual perceives norms or role expectations held individually or collectively by other family members for his attributes and behavior " (Hill & Hanson, 1963). A key concept here is that an individual learns to interpret and value certain items and skills through interaction with his/her environment. The individual is born into a context of predefined symbols whose meanings have been inherited. Relative to incest there are interpretations and meanings which are passed on from one family to another that may increase the

vulnerability of a family. The inherited roles, perceptions, and expectations may produce a momentum of influence that becomes difficult to change.

Even though the individual is dynamic and continually interacts with the environment, this inherited frame of reference becomes the screen through which all else must pass and be built upon. Behavior is influenced by the symbols within the mind and it is through those symbols that meaning is given. Individuals conceive of themselves in terms of roles, and integrated sets of social norms that are preestablished.

An individual may learn the norms, expressions, and behaviors of several roles. Those interacting with the individual must agree on the expectations of a particular role. If no agreement is obtained, role strain is the stress felt when they attempt to meet these expectations. As strain is felt and opportunity for redefinition or change occurs, role transition is then possible and a new role is acquired.

(2) General Systems. Minuchin (1976) states that: "...an individual is an interdependent, contributing part of the systems that control his or her behavior. The focus is upon functioning within the system rather than internal processes of the individuals. Patterns are developed and maintained in the family through time and regulate the behavior of system members. He or she is never truly independent and can only be understood in context."

While symbolic-interaction requires a transactional element between family members, it is the internal mental process that is emphasized, creating and interpreting interaction symbolically, thus influencing behavior. General Systems Theory places emphasis upon the transactional component. It is interaction that influences behavior, not any interpretation or internal processing. By integrating these two theories where they overlap, a more complete explanation can be made about the interplay between the whole family system and its various subsystem combinations, including the individuals that make it up.

One main tenet here is that a family will seek to maintain and stabilize its transactional patterns (structure). This attempt to stabilize is termed "homeostasis". In general systems thinking, interactions are regulated by rules and established patterns within the family. This regulation is accomplished by the monitoring of information going out and coming in, "feedback". There are implicit family rules which prescribe family response to input. The monitoring allows choice of the "best rule". Strain is felt on the family when a new set of circumstances is encountered for which there are no adequate rules. "Morphogenesis" is the creation of a new rule whereby the family structure is changed or the goals of the system altered.

(3) Family Stress. "The family is a reactor to stress and a manager of resources within the family system"

(Burr, 1973). A healthy family will maximize its resources to meet extrafamilial and intrafamilial demands. The less effectively the resources are managed, the more vulnerable the family and its members become. The term vulnerability refers to; "The interpersonal and organizational condition of the family system shaped by: (1) the pile-up of demands on or within the family unit co-occurring at the onset or impact of another stressor or transition and (2) the family's life cycle stage with all of its normative demands and variability in resources and strength."

The theory concerning family stress identifies the importance of the family as a system to respond to stressor pile-up by mobilizing its resources, adjusting and adapting. It also emphasizes the importance of the perceptions and developmental transitions of individual and family systems.

The following are a list of ingredients for family adaptation and adjustment;

a. Seeking information and understanding of the stressor event.

b. Seeking social support from friends, relatives, and neighbors.

c. Being flexible about family roles.

d. Improving family member communication.

e. Perceiving problems as solvable.

The family's life cycle stage development is defined as; "A schema which emphasizes the major points at which

family members enter and exit from the family system, upsetting the family homeostasis. The central underlying process to be negotiated is the expansion, contraction, and realignment of the relationship system to support the exit, entry, and development of family members in a functional way " (Carter & Goldrick, 1980).

Taking into account the concept that symptoms reflect family life-cycle derailment or the inability of the family to cope with the transitions that occur developmentally, Carter & McGoldrick (1978) emphasize the importance of the dimensions of the current life-cycle stress and also its connections to family themes, triangles, and labels (symbols) coming down in the family over historical time.

The common overlap for all three of these frameworks portray change as requiring first a strain or lack in current resources. All three note the capability of self-monitoring, selection, or adjustment to obtain new resources. All three define success of this transition as requiring some type of affirmation from the system.

My integration of these theories is focused primarily upon their differences in explaining the family's adaptation and adjustment to change. All three agree that the success of a family's encounter with change lies with its ability to adjust and adapt. The differences lie in what factors each theory emphasizes to explain this adaptation and adjustment. For General Systems theory this adjustment adaptation is accomplished

transactionally among family members. Symbolic Interaction explains adjustment adaptation through internal processes that interpret transactions. Family Stress Theory includes developmental and extrafamilial explanations to the transactional and internal process components. Of primary importance is the family's individual and collective perceptions and interpretation of the occurrence.

All of these theories, when integrated, bring into focus factors showing strong connections to incest: boundaries, perceptions, expectations, family functioning, family of origin issues, and context. Finkelhor (1986) emphasized intrafamilial elements: "In general, the background factors that have shown the strongest connection to incest, both across and within studies, have been those relating to parents and family." Russell (1986) notes in her recent study the need to move toward social factors when researching incestuous abuse, thus calling attention to the boundaries between intra-familial and extrafamilial systems. Larson (1980) proposes that incest be understood as a reflection of "boundary disturbances," divided into four areas: "...(1) the boundary between the family and its social environment; (2) the boundary between adult and child generations in the family; (3) interpersonal/role boundaries between family members; and (4) intrapsychic boundaries within family members."

The application of this focus to father-daughter incest and to my research is that rules are maintained by the family. When difficulties arise, the family is limited to the resources available to them unless new ones can be created and/or agreed upon.

It is the family that consensually agrees upon how respond within their system. It is the individual family member who influences and is influenced by the family's consensus. These factors are perpetuated intergenerationally and in some families, enhanced and maintained at a level which makes the family vulnerable for father-daughter molest to occur.

Chapter II

Review of the Literature on Father-Daughter Incest

Prior Models of Incest Explanation

There have been attempts in the past to identify a single factor or an individual characteristic responsible for father-daughter incest. The following three models subsume most of what has been offered in explanation for the phenomena of father-daughter incest.

These explanations for father-daughter incest both overlap and contradict (Renshaw, 1982). It is their integration, however, that presents us with a more complete picture. Failure to recognize this multi-factored relationship allows only a partial view of this entire phenomena. I propose an integration and testing of explanations and consensual patterns offered to-date.

The Freudian Model This model relies heavily upon theories of infant sexuality. The Oedipus-Electra complex places responsibility not on the male but upon the female victim motivated by unresolved sexual conflicts (Freud, 1933). Reliance is placed on the patriarchal society where mother-son incest is abhorred as an insult to male supremacy. Father-daughter incest is less threatening, therefore the taboo is broken more often.

The Victim-Perpetrator Model This has been the most predominant model. Its main tenet proposes that incest is an aggressive act of a pathological or deviant adult (Trepper & Barrett, 1986; Groth, 1980; Sgroi, 1981;

Geiser, 1979; Mayer, 1985). The most popular explanation of this model groups all child molest offenders into two categories; (1) Fixated - These are men who have been sexually attracted to children since their adolescence. It is believed that their emotional and psychological development has been arrested due to their own abuse. Their motivation is sexual, not a need for power or control. The pedophile is placed into this category. (2) Regressed - This is an adult whose relationships are extremely unsatisfying, stressful, and laden with anxiety. Their motivation to molest children is primarily control, power, and affection. This father-daughter incest offender is placed in this category (Groth, 1980).

The Social-Structural Model Feminist writers have proposed a social-structural theory that focuses on patriarchal society and family relationships, wherein power invested in men and fathers contributes to abuses of women and children (Mayer, 1983; Butler, 1978). This model proposes that women are raised to be victims: passive, weak, and dependent upon the male. The male is socialized to view women and children with contempt, as possessions to be conquered. The socialization process is the main causative factor in incestuous abuse (Finkelhor, 1987).

Factors Associated with Father-Daughter Incest Explanation

Factors relative to the individual offender and non-offending spouse as well as the family as a whole have been gathered from past literature and listed in figure 3. They are presented as a list of explanatory factors from many schools of thought and many disciplines. My rationale for gathering them in one place is that father-daughter incest is not a single-factored phenomena but multi-factored. This exploratory analysis is designed to identify that which is viable. Individual victim factors were not presented nor were they investigated due to the difficulty in obtaining personal information from a traumatized child.

Father Factors

The offender factors offered historically have been (Horowitz, 1985; Sgroi, 1982; Anderson & Shafer, 1979; Deisher, 1982; Gottlieb, 1980; Mayer, 1983):

(a) self-alienation

(b) insecurity

(c) despondency

(d) rigidity

(e) fear of being unable to function adequately in a heterosexual relationship.

(f) higher score in the MMPI on the Social Introversion Scale than non-incest child molesters (Panton, 1979)

(g) aggression and a need to express personal power

(h) underdeveloped peer relationships

(i) social isolation

(j) feelings of inadequacy

(k) poor impulse control

(l) physical rather than verbal expression of needs

(m) extensive use of manipulation to achieve need satisfaction

(n) inability to tolerate intimacy with adults

(o) unwillingness to seek sexual satisfaction outside of the family

(p) low self-esteem

(q) emotional & sexual immaturity

(r) previous sexual abuse by a family member

(s) passive-dependent & passive-aggressive character who expresses anger covertly

Mother Factors

Those factors commonly attributed to the mother in father-daughter incest are (Sgroi, 1982; Finkelhor, 1985; Mayer, 1983; Anderson & Shafer, 1979):

(a) extremely passive or dominating

(b) emotionally disengaged from the family

(c) low self-esteem

(d) feelings of inadequacy as a wife and mother

(e) extremely dependent

(f) emotional immaturity

Family Factors

Five "typical" patterns have been supported in most of the available literature (Meyer, 1983; Garbarino & Gilliam, 1980; Rist, 1979; Schlesinger, 1982; Lustig, Dresser, Spellman, & Murray, 1966) as indicators of father-daughter incest; (1) Marital discord and a poor sexual relationship between the parents; (2) Confused roles and generational boundaries as evidenced by the reversal of mother and the daughter roles which makes the daughter the central female figure in the home with the responsibility of satisfying the needs of the father; (3) Social isolation; (4) Enmeshment (dependence with little support, blurred boundaries, little personal physical or psychological privacy); and (5) Communication is predominately indirect and non-verbal.

I have reviewed the most commonly noted factors and patterns related to fathers, mothers and their families where incest has occurred. These factors are subsumed in a listing of components of family risk (figure 3). They are separated into Offender Potential Factors and Family Vulnerability Factors for the purpose of clarifying the premise of this study that it is the combination of offender potential and family vulnerability that determines family risk for father-daughter incest to occur.

Past literature has provided; (1) Factors identified with father-daughter incest, and (2) Explanations for the factors. Many of the factors overlap even though the

explanations for them do not and even sometimes contradict eachother. The purpose of this study is to; (1) Validate factors, (2) Provide a new integrative explanation for them.

Offender Potential Factors:

- Individual Personality
  - extroversion/neuroticism
- Sexuality
  - relationships
  - family of origin influence
- Family of Origin/Perceived Health
  - autonomy - clarity of expression
    - responsibility for self
    - respect for others
    - openness to others
  - intimacy - range of feelings
    - mood and tone
    - conflict resolution
    - trust
    - empathy

Family Vulnerability Factors:

- Individual Personality of the mother
- Family Adjustment/Adaptation
  - stressors
  - isolation
  - distress
  - family life-cycle
- Family Structure
  - enmeshment/disengagement
  - father-child cohesion/disengagement
  - mother-child cohesion/disengagement
  - flexibility/rigidity
  - cross-generational coalition
  - spouse conflict resolved/unresolved
  - family conflict avoided/expressed
  - child overprotection/autonomy
- Sexuality
  - non-offending spouse
- Family of Origin/Perceived Health
  - non-offending spouse

Figure 1. Components of Family Risk

Hypotheses

The research hypotheses:

Relative to non-incestuous families, incestuous families will be characterized by:

(1) More fathers being identified in the extroversion grouping as measured by the Eysenck. Fathers who molest their daughters are not satisfied with one partner and are seeking more varied sexual experiences (Barnard, 1984). Theory about extroversion discusses this propensity for multiple partners and more varied, socially unacceptable behavior (Eysenck, 1964).

(2) Lower adaptation and adjustment scores as measured by the FIRA-G. Incestuous families see themselves as multi-problemed and overwhelmed with the changes in their lives (Anderson & Shafer, 1979).

(3) Significantly lower scores on the HCSQ by the father. Sexual experiences in childhood and adulthood results in poor sexual adjustment of fathers who molest (Finkelhor, 1986).

(4) Significantly lower scores on the Family of Origin Scale by the father. Some fathers who molest their daughters have had physically and or emotionally negative experiences in their families of origin (Gabarino & Gillian, 1980). These negative experiences influence not only how they organize their own current family but also how they feel about themselves. Fathers who molest frequently have low

self-worth (Russell, 1986).

The following hypotheses will be tested by administration of the SFIS-R scale:

(5) Enmeshment of the family. Incestuous families are frequently described as being enmeshed. Individual member boundaries (physical and emotional) are frequently violated (Trepper & Barrett, 1986).

(6) Parental overprotection of the children. Incestuous families are often isolated from extrafamilial intrusion and enmeshed. Children are objectified and seen as possessions to meet the insecurity needs of the parent(s) (Tucker-Adams, 1981).

(7) Rigidity within the families rules and roles. Incestuous families have often been noted to have a limited ability to respond adaptively to change. There is a fear that the family will not survive if it changes (Conte, 1985).

(8) Father-child cohesion is often referred to in incest literature (Finklhor, 1986) as a component of incestuous families. Father replaces many of the adult emotional and sexual factors of his relationship with his wife with the one he has with his daughter.

(9) The avoidance of family conflict. Incestuous families deal indirectly with problems that arise in an effort to maintain the stability and status quo of the family (Orten & Rich, 1988).

(10) Unresolved spouse conflict. As stated above, conflict is dealt with indirectly and seldom resolved in incestuous families.

(11) Cross-generational triads. Incestuous families are described as having fathers who replace their wives with their daughters, mothers and daughters who reverse their roles in the family (Sgroi, 1982).

(12) Mother-child disengagement. As a part of the reversal of mother-daughter roles, distance and increased conflict is included as part of the incestuous family's description (Sgroi, 1982).

In addition to determining whether these characteristics are associated with the known groups in my sample, I will also determine what combination of variables best predicts group membership. Figure 2 is an overview of this study's design. Groups were compared on the variables; SES, family-size, and family step-relationships.

THEORETICAL FRAMEWORK
Symbolic Interaction
General Systems
Family Stress

PREVIOUS EXPLANATIONS FROM RESEARCH AND LITERATURE

TWELVE VARIABLES
Personality
Sexuality
Family of Origin/Perceived Health
Family Enmeshment/Disengagement
Parental Overprotection
Family Flexibility/Rigidity
Family Conflict Avoidance
Spouse Conflict
Cross-Generational Triads
Father-Child Cohesion/Disengagement
Mother-Child Cohesion/Disengagement
Family Adjustment/Adaptability

HYPOTHESES

FIVE SELF-REPORT MEASURES ADMINISTERED TO BOTH PARENTS
The Heterosexual Couples Sexuality Questionnaire
The Structural Family Interaction Scale
The Eysenck Short Questionnaire
The Family of Origin Scale
The Fira-G

THREE SAMPLE GROUPS *
Clinical Non-Incest Group
Clinical Incest Group
Non-Clinical Group

Figure 2. Overview of Integrative Study Design

Chapter III

Method

Subjects

The sample is divided into three groups: (1) clinical incest group, (2) clinical non-incest group (to control for clinical status), and (3) non-clinical group (see Table 1). The entire clinical incest group (fourteen couples), and three couples from the clinical non-incest group were obtained from The Community and Family Resource Center in Lafayette, Indiana. The eight remaining couples for the clinical non-incest group were obtained from The Marriage and Family Therapy Clinic at Purdue University in West Lafayette Indiana. The non-clinical group (fifteen couples) were obtained by contacting a girl scout troop, day-care centers, and a neighborhood recreation center in Lafayette, Indiana.

The entire sample consisted of eighty caucasian individuals (forty couples). Sixty-six percent of these individuals were between the ages of thirty and forty years old. The remaining thirty-four percent were tapered evenly in a range between twenty-one and forty-eight years old. Sixty-eight of these individuals were currently married, six were currently separated, four currently divorced, two were currently living together. The five separated and divorced couples were together until the report of father-daughter molest to the authorities. Eighty-two percent had been married to their current or

most recent partner for seventeen years or less with the maximum being twenty-three years. Of the eighty individuals, sixty-nine of them had completed high school, twenty-one of them some college, and eight completed college. Eleven had not competed high school.

All groups were compared on the variables of annual income, household size, and father-daughter step-relationships. For all three groups the average income was above 10,000 and below 19,999 annually. There were seven stepfather relationships in the clinical-incest, four in the non-clinical groups, and six in the clinical non-incest group. For the variable of household size, the clinical-incest group averaged 4.1 people, clinical non-incest 4.3, and non-clinical 3.6.

A Oneway ANOVA statistical technique was utilized to determine if there were any statistically significant differences between the three groups on the demographic variables; household size, education, age, marital status, years with partner, combined income, and father-daughter step-relationships. The results showed the groups were comparable on all variables except age.

Clinical incest samples were obtained before being placed on a waiting list or assigned a therapist. Clinical non-incest samples were obtained before five sessions had been completed by a therapist. They were comparable to the clinical incest sample on; SES, father-daughter step-relations, and household size. Therapists would identify potential families and would present the

study to them, asking that they volunteer their participation. An informed consent form was provided to each family member and a brief demographic questionnaire was completed.

Table 1.
Demographic Data for Three Groups of Couples

VARIABLE	CLINICAL INCEST N=14	CLINICAL NON-INCEST N=11	NON-CLINICAL N=15
Age-Husband			
M(SD)	38.0(5.84)	34.2(4.64)	35.7(4.84)
Range	29-46	25-41	26-48
Education-Husband (Frequency & Percent)			
grade school:			
1. some	X	X	X
2. completed	X	X	X
high school:			
3. some	3 & 21%	2 & 18%	X
4.completed	6 & 43%	5 & 46%	9 & 60%
college:			
5. some	4 & 29%	3 & 27%	3 & 20%
6. completed	1 & 7%	1 & 9%	3 & 20%
graduate school:			
7. some	X	X	X
8. completed	X	X	X
* One from the Non-Clinical group attended a special training program after high school.			
Age-Wife			
M(SD)	34.4(6.92)	30.3(5.69)	34.7(4.78)
Range	24-46	21-40	26-44
Education-Wife (Frequency & Percent)			
grade school:			
1. some	X	X	X
2. completed	X	X	X
high school:			
3. some	3 & 21%	2 & 18%	1 & 7%
4. completed	6 & 43%	6 & 55%	7 & 47%
college:			
5. some	4 & 29%	2 & 18%	5 & 33%
6. completed	1 & 7%	X	X
graduate school:			
7. some	X	X	X
8. completed	X	X	X
* One from the Clinical non-incest group attended a special training program after high school.			

Table 1. Continued...

VARIABLE	CLINICAL INCEST N=14	CLINICAL NON-INCEST N=11	NON-CLINICAL N=15
Marital Status (Frequency & Percent)			
1. never marr.	X	X	X
2. married	10 & 72%	9 & 82%	15 & 100%
3. separated	2 & 14%	2 & 18%	X
4. divorced	1 & 7%	X	X
5. widowed	X	X	X
6. cohabitating	1 & 7%	X	X
Years with Partner			
M(SD)	10.8(6.53)	11.4(5.71)	12.2(5.35)
Range	4-21	4-23	6-23
Combined Income (Frequency & Percent)			
1.<10k	1 & 8%	1 & 9%	X
2.>10k<20K	7 & 50%	7 & 64%	9 & 60%
3.>20k<30k	5 & 35%	3 & 27%	4 & 27%
4.>30k<40k	1 & 7%	X	2 & 13%
5.>40k<50k	X	X	X
6.>50k	X	X	X
Household Size			
M(SD)	4.1(1.39)	4.0(1.48)	3.6(.737)
Range	3-8	3-8	3-5
Stepfathers (Frequency & Percent)	7 & 50%	4 & 36%	6 & 40%

* Of the demographic variables, Age was statistically significant at the .05 alpha level using a Oneway ANOVA statistical technique comparing the three groups.

Instruments

The following five instruments are all self-report measures and were arranged in a packet for this study. The packet was titled C.A.T.E - Core Assessment & Treatment Evaluation.

The FIRA-G

The Family Inventory of Resiliency and Adaptation (FIRA-G),(Mcubbin & Thompson, 1981); This measure is designed to obtain seven indices of family functioning. It consists of a battery of seven short questionnaires which produce interval level scores. All items are in the form of statements; (1) The Family Stressors Index is nine items. The scale is bipolar with a yes/no response to choices of life events. Respondents indicate whether or not they experienced specific life events. There are weights assigned to each item based upon the severity of the stressor. For example; "A family member started or returned to work." receives less weight (41), than "A family member, close relative or close friend died." receives at (73). It has a concurrent validity (correlation with the original FILE) of .60. The original FILE (Family Inventory of Life Events and Changes) with which it is correlated is a seventy-one item self-report instrument designed to record normative and non-normative life events and changes experienced by a family unit. FILE has an internal consistency reliability (Cronbach's Alpha) of .72, and a test-retest reliability (Pearson

correlation) over five weeks of .77. Construct validity was reported by negative correlations with the Family Environment Scale (Moos, 1974) ranging from -.14 to -.24.; (2) The Family Strains Index is ten items. It is also a bi-polar scale (yes/no choices) with stressor weights assigned to each choice based upon the severity of the strain. For example; "Increase or conflict with in-laws or relatives." receives less weight (40) than, "Increase in conflict between husband and wife." receives at (53). It has a reliability index (internal consistency) Cronbach's Alpha of .69 and a concurrent validity (correlation with
the original FILE) of .87.; (3) The Relative and Friend Support Index is eight items with a five-point Likert response scale that ranges from "strongly disagree" to "strongly agree". Each item is in the form of a statement. It has a reliability (internal consistency) Cronbach's Alpha of .82 and concurrent validity (correlation with the original F-COPES) of .99. The original F-Copes (Family Crises Oriented Personal Evaluation Scales) with which it is correlated is a thirty item self-report instrument created to identify problem-solving and behavioral strategies utilized by families in difficult or problematic situations. F-Copes has an internal consistency (Cronbach's Alpha) of .77, and a test-retest reliability (Pearson correlation) over five weeks of .71. Information on validity was not available; (4) The Social Support Index is seventeen items with a

five point Likert response scale that ranges from "strongly disagree" to strongly agree". Each item is in the form of a statement. It has an internal consistency Cronbach's Alpha of .82 and concurrent validity (correlation with the criterion of "Family wellbeing") of .40 (Mcubbin & Thompson, 1981).; (5) The Family Coping-Coherence Index is a four item questionnaire with a five point Likert response scale that ranges from "strongly agree" to strongly disagree". Each item is in the form of a statement. It carries an internal consistency reliability Cronbach's Alpha of .71 and a concurrent validity (correlation with the original F-COPES) of .80.; (6) The Family Hardiness Index is twenty items. It has a four point Likert response scale that ranges from "mostly true" to mostly false". Each item is in the form of a statement. Internal reliability consistency is a Cronbach's Alpha of .71 and content validity coefficients range from .15 to .23.; (7) The Family Distress Index is five items with a bi-polar scale (yes/no choices) and stressor weights based upon item severity for each choice. For example; "A family member appeared to depend upon alcohol and/or drugs." receives less weight (66) than "Physical and/or psychological violence in the home." receives at (79). The psychometric properties of this instrument have not been investigated. It has a concurrent validity (correlation with the original FILE) of .50.

Normative data tables based upon family life cycle

stage development were used for the comparison and establishment of an overall adjustment and adaptability score for each couple in the sample. This adjustment/adaptation score was established for each couple by combining these seven separate measures of family functioning. Three of the measures assess the amount of distress and stressor pile-up; The Family Stressors Index (FSE), The Family Strains Index (FSA), and the Family Distress Index (FDI). For all three measures a lower score is interpreted as a lower amount of stress and distress being experienced by the family. Four measures assess the amount of support and resources the family has available to them; The Relative and Friend Support Index (RFS), The Social Support Index (SSI), The Family Coherence Index (FCI), and The Family Hardiness Index (FHI). For all four of these measures a higher score is interpreted as a higher amount of support and resource availability.

A single score of adaptation/adjustment was assigned to each individual by subtracting their stressors score from their support and resources score. The rationale being that these two constructs are inseparably linked to assess the family's overall ability to adjust and adapt to the stressors and strains it experiences, based upon the support and resources it has available. Table 4 demonstrates the comparability of three previous surveys (McCubbin & Thompson, 1981) and this study for each of the seven measures in the FIRA-G battery.

Table 2. The FIRA-G Comparison Table

Measures	CI	NC	NI	Comparative Data
	(M) STDDEV	(M) STDDEV	(M) STDDEV	(M) STDDEV
RFS	(23.1) 6.0	(22.0) 6.0	(25.0) 4.0	(25.0) 6.0
SSI	(43.4) 8.0	(39.7) 7.0	(43.0) 5.0	(45.3) 7.5
FSE	(13.0) 6.0	(9.0) 6.3	(15.0) 7.0	(11.0) 8.0
FSA	(18.0) 7.0	(9.0) 5.0	(17.0) 8.0	(11.0) 8.0
FHI	(46.2) 7.6	(49.4) 7.9	(42.1) 3.9	(47.5) 4.9
FCI	(15.0) 2.4	(16.2) 3.5	(15.3) 2.0	(16.0) 2.0
FDI	(15.0) 14.2	(4.0) 6.0	(16.0) 8.0	(2.0) 1.0

The Eysenck Personality Questionnaire

The Eysenck Short Questionnaire for the Measurement of Two Dimensions for Personality (Eysenck, 1964); The Eysenck is a bi-polar, twelve-item yes/no response questionnaire. It produces a nominal level score denoting its two subscales, neuroticism (N) and extraversion (E), of six items each. The items for this shorter version of the original Eysenck questionnaire were selected from a previous item-analytic and factor-analytic study. A sample of 1,600 subjects equally divided as to age, sex, and class were given the questionnaire. A factor analysis was performed affirming the previous analysis of the two personality
variables.

Both scales show considerable independence. None of the E items has loadings on N as large as .10 and none of the N items has loadings on E as large as .10. The correlation between E and N is -.05. The split-half reliabilities are .79 for N and .71 for E. No information was available for the validity of this measure.

The Family of Origin Scale

The Family of Origin Scale (Hovestadt, Piercy, Anderson, Fine & Cochran, 1985); This is a forty item questionnaire with a Likert response scale that ranges from "strongly agree" to "strongly disagree". Each item describes some aspect of family health in the respondent's family of origin. Respondents are asked to indicate the degree to which each statement matches their family of origin. The resultant score is interval level. It is a measure of self-perceived levels of health in one's family of origin. The scale has a test-retest reliability coefficient of .97 ($p < .001$) over two weeks. A Cronbach's alpha of .75 and a Standardized Item alpha of .97 were also obtained. Content validity was established by a panel of six nationally recognized experts in the field of family therapy. The scale was administered with other related measures in two separate studies (Rational Behavior Inventory, Healthy Family Functioning Scale, and the Personal Information Form) with significant results (Hovestadt et al, 1985).

The Structural Family Interaction Scale

The Structural Family Interaction Scale (Perosa, Hansen, & Perosa, (1981); This scale has seventy-seven items with a four point Likert response scale that ranges from "very true" to "very false". Each item is in the form of a statement about some aspect of family relationships as perceived by the respondent. The score produced for each subscale is interval level. It is used to measure family interaction patterns. Minuchin's structural model of family functioning was the guiding theory during its development. The overall inter-rater reliability for the content of the items was .950. The factor-analyzed loadings for the scales are; Spouse conflict resolved/unresolved (.90), Father-child cohesion/estrangement (.90), Mother-child cohesion/estrangement (.84), Flexibility/rigidity (.81), Enmeshment/disengagement (.92), Overprotection/autonomy (.86), Parent-coalition/cross-generational triads (.81), and Family conflict avoidance/expression (.82). Test-retest reliability is in the .70 to .90 range for every scale. Inter-scale correlations replicate well the patterns predicted by Minuchin's theoretical conceptualizations.

The Heterosexual Couples Sexuality Questionnaire

The Heterosexual Couples Sexuality Questionnaire (HCSQ); This is a quantified integration of The Purdue Sexuality Questionnaire (Fontaine & Trepper, 1986), the

Index of Sexual Satisfaction (Hudson, 1982), The Maltz Sex Inventory (Maltz Counseling Associates, Eugene, Oregon, 1987), and assessment recommendations from various experts in the area of sexuality (Masters & Johnson, 1966; Kaplan, 1974; LoPiccolo, 1978). It has seventy-three items with a four-point Likert response scale that ranges from "very true" to "very false". Each item is in the form of a statement about the respondent's sexuality. The score produced is interval level.

The HCSQ assesses four components of sexuality; family of origin disclosure, current relationship sexual satisfaction, positive sexual orientation experiences, and negative sexual orientation experiences. An exploratory factor analysis was performed through SPSS-X on seventy-three items to identify factors latent in the measure. Eighty individuals (the forty couples from this study) made up the sample. A Maximum Likelihood Extraction was used to estimate population values for factor loadings. Factor loadings are the correlations between a variable (in this case a test item) and a factor. These estimates maximize the probability of sampling the observed correlation matrix from a population. The Kaiser-Meyer-Olkin (KMO) measure of sampling adequacy and matrix factorability was .29 showing a moderate level of acceptability. A Bartlett's Test of Sphericity resulted in a significance of .001, interpreted as a unique and non-random data set.

A Scree test was performed and Eigenvalues examined

to note the number of factors present. Four factors were noted above an eigenvalue of 4.0. The seventeen remaining trailed off at 2.0 or below. Four factors were forced in the factor analysis based upon the four factors presumed in the measure's development.

An oblique rotation technique (Oblimin) was performed due to the presumed correlation of the factors. A Varimax rotation (an orthogonal technique presuming independence) was also performed due to the exploratory nature of analysis and yielded poor results. Two tables are presented; The Oblimin Rotation loadings (table 3), and The Factor Correlation Matrix (table 4). Loadings of .30 and above were selected for interpretation. Loadings below .29 were not reported.

Comrey (1973) notes that loadings of .29 and less are not significant enough to consider as meaningful. Loadings of .30 account for 9% of the variance overlap between the factor and the item, .45 (20%), .55 (30%), .63 (40%), and .71 (50%).

The results of the postrotation loadings yielded a total of forty-two items with nine loadings on factor #1, ten loadings on factor #2, eight loadings on factor #3, and fourteen loadings on factor #4. The factor correlation matrix shows the independence between the factors.

Internal consistency reliability (Cronbach's Alpha) for all seventy-three items was .84. The Internal consistency (Cronbach's Alpha) for factor #1 items was

.88, factor #2 .84, factor #3 .71,and for factor #4 items it was .81.

Discriminate validity was explored atheoretically using a T-Test procedure comparing husband and wife scores in the non-clinical group. A significant result of .041 at an alpha level of .05 (two-tailed probability) was obtained.

Test-retest reliability was established by using a different sample. Twelve married caucasian couples between the ages of twenty-three and thirty-four with at least one partner in a graduate program, were administered the HCSQ. Six weeks later the HCSQ was re-administered to the same group. The test-retest reliability result was a Pearson Correlation Coefficient of .73.

Table 3. The Oblimin Rotation Loadings

Item	Factor #1	Factor #2	Factor#3	Factor #4
5	**.68339**	-.01799	-.12979	.07297
6	**.59455**	-.12784	-.02495	.02554
7	**.36006**	-.16598	-.23197	-.25798
8	**.69373**	-.08682	-.03848	-.05304
9	**.75190**	-.13474	-.01868	-.13127
10	**.81823**	.12714	-.13077	.05662
11	**.74360**	.09638	-.17423	.07217
12	**.67844**	.05016	-.13189	-.08788
13	**.67803**	-.14981	-.18024	.26825
22	-.09006	**.44124**	-.29137	.00908
23	.02709	-.02096	**.53229**	.00861
24	.22776	.19153	**.34526**	-.04282
26	.21543	.00525	**.33793**	-.03705
27	.21240	-.08701	-.00454	**.61489**
29	.13909	-.07313	-.07697	**.56840**
30	-.07606	-.02508	-.01253	**.46844**
31	.19726	.13153	-.01117	**.46115**
32	.14530	.13528	**-.40683**	-.00806
34	.18635	-.22750	.04416	**.30067**
35	-.16124	**.66200**	-.00265	-.15298
36	.03740	**.61328**	-.07748	-.00780
37	-.02155	**.66318**	-.06451	.20039
38	-.05394	**.66347**	-.13540	.19892
39	-.05016	**.59021**	-.19439	.04162
40	-.02702	**.73166**	.05839	-.12156
49	.16720	.23616	**.31492**	.29388
51	.23167	.24561	**.33184**	.20558
52	-.07632	.19908	.16289	**.30025**
55	-.25024	.19379	**-.40183**	.03601
57	.03969	**.41468**	-.16586	-.06078
58	-.05973	-.04019	.19404	**.37731**
59	-.03730	.01314	.00126	**.54436**
60	-.10628	.18291	-.11136	**.51000**
62	-.01362	-.02133	.07543	**.43982**
63	.12003	.01906	-.03737	**.48869**
64	.05222	.12189	**-.39863**	-.10343
68	-.23064	.11844	-.21791	**.45394**
69	-.04727	.03097	.06836	**.49870**
70	-.16343	.10213	-.06655	**.58263**
71	-.27963	**.57335**	-.20112	-.18515
72	-.03197	**.51856**	-.14963	.27908

Table 4. The Factor Correlation Matrix

	Factor 1	Factor 2	Factor 3	Factor 4
Factor 1	1.00000			
Factor 2	-.01518	1.00000		
Factor 3	-.01706	-.14233	1.00000	
Factor 4	.03742	.07427	.01274	1.00000

Procedures

The designated assessor at each site was given a C.A.T.E. (core assessment & treatment evaluation) packet for each couple. The packet consists of thirty pages which contain instructions for administration of C.A.T.E., the five measures described above, demographic information, family information, and consent forms. All forms are completed by both parents except the family information form which contains a severity of molest scale and was completed by the assessor for the clinical-incest group only. Each couple was assigned a code number. All other identifying information was removed.

The Integrative Research Model Diagram (figure 1) describes the variables being tested and how they combine to influence risk for father-daughter incest.

There are three independent variables which combine to influence the resulting family structure established by both parents; (1) Individual Personality - According to theory, extroverts are not easy to condition and therefore less likely to be responsive to socialization efforts, resulting in behaviors that are not socially approved of.

Sexually, extroverts are more likely to seek stronger sensory stimulation and as a result will indulge in more varied sexual behavior, more frequently, and with more varied partners than introverts (Eysenck, 1964).

Respondents will receive a score identifying their degree of extroversion/introversion (neuroticism) as measured by the Eysenck Short Personality Questionnaire, (2) Sexuality - The sexual adjustment of a father who chooses to seek gratification through his child is assumed to be quite poor. The influence of childhood experiences in the family of origin and adult experiences of both father and mother are measured by the Heterosexual Couples Sexuality Questionnaire; and (3) Family of Origin/Perceived Health - Self worth is an important factor in both parents but particularly the father who molests. How one perceives his/her family of origin experience can be an important method for determining self-worth. This factor will be measured by The Family of Origin Scale.

The resulting Family Structure that is organized by father and mother consists of several components. In order to examine this family structure to determine its uniqueness from other non-incestuous structures, eight independent variables will be assessed: (1) Enmeshment/Disengagement - Is the family too close or too distant in reference to their relationships with each other?, (2) Flexibility/Rigidity - Can family rules and roles change and adapt?, (3) Cross-generational Coalitions

- Do the adults in the family "team-up" inappropriately with the children against other adults?, (4) Spouse Conflict (resolved/unresolved), (5) Child Overprotection/Autonomy - What is the level of independence and individuation children are allowed from the parents?, (6) Family Conflict - What is the level of perceived family conflict?, (7) Father-Child Cohesion/Disengagement - Is the father close or distant in their relationship with the victim?. (8) Mother-Child Cohesion/Disengagement - Is the mother close or distant in their relationship with the victim? All eight variables are measured by The Structural Family Interaction Scale-Revised.

The question of how an incestuous family perceives and manages stressors that occur in their lives arises from the literature on incest. Family Adjustment & Adaptation in this model is an intervening independent variable. Mother and father join together with their unique individual personalities, family of origin, and sexual experiences and beliefs to create a unique family identity and structure. Intrafamilial and extrafamilial stressors and changes test this family structure and it is their response to these challenges that is being examined. An overall score of adjustment and adaptability is given to the family by both the father and the mother of the family as measured by the FIRA-G which identifies family's stressor pile-up and ability to cope with the resources available to them. A failure to successfully manage these

changes, when combined with certain other factors may result in greater risk for father-daughter incest to be chosen by a father with high potential to molest in a vulnerable family system.

The dependent variable is Father-Daughter Incest identified by referral and acceptance to a treatment clinic. In sum, there are three independent variables (personality, sexuality, & family of origin/perceived health) which combine to help define eight more independent variables of family structure. The intervening independent variable (adjustment/adaptation) influences and challenges the function/dysfunction of he family system whereby risk is determined for the dependent variable of father-daughter incest.

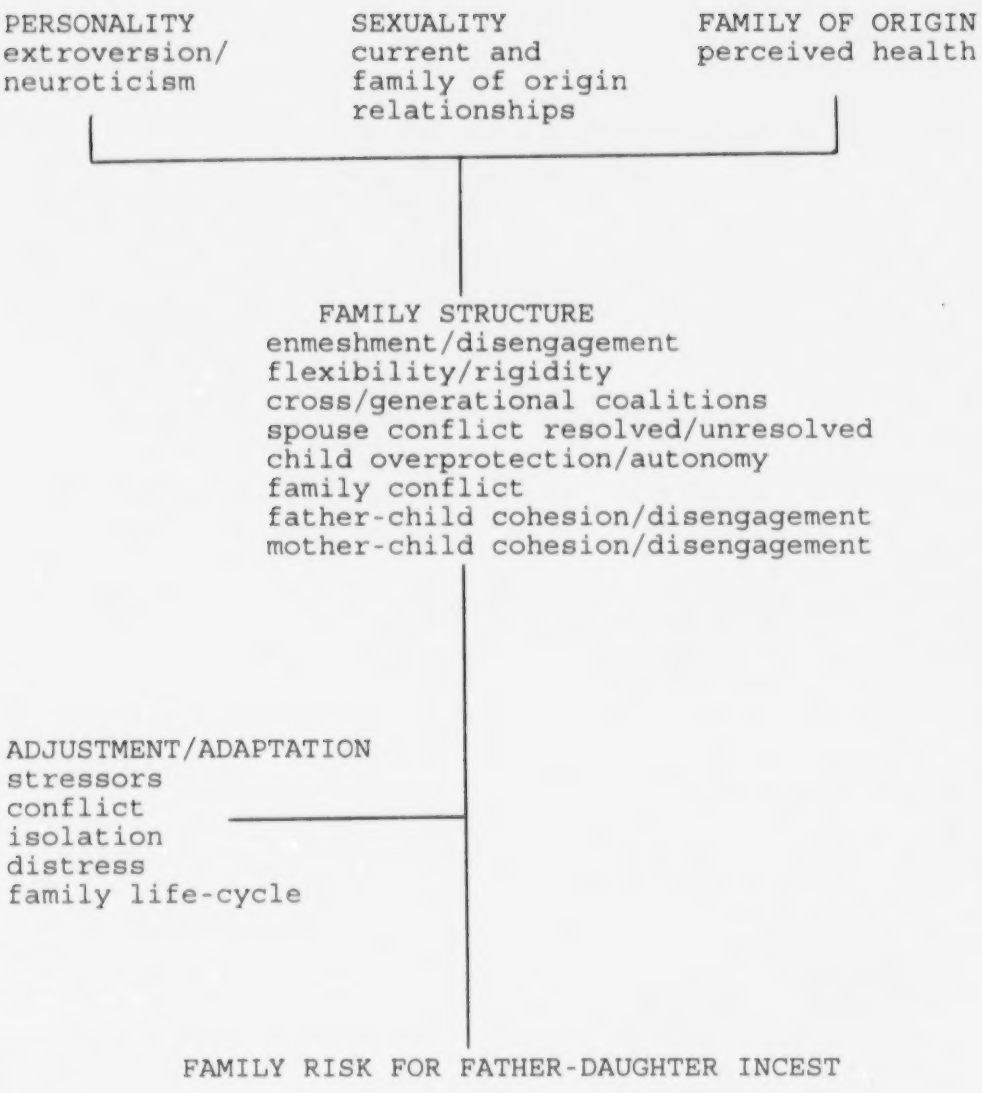

Figure 3. Integrative Research Model Diagram

Data Analyses

The Discriminant Function Analysis statistical procedure involves the use of a categorical dependent variable (groups), and relates it to a number of continuous independent variables. The difference between two or more groups on two or more variables is tested for significance. This procedure was used in this study to determine what combination of twelve variables; adaptation /adjustment, sexuality, perceived health, extroversion /neuroticism, personality, sexuality, family of origin, and adaptation best predicts group membership in the clinical-incest, clinical non-incest, and non-clinical groups.

The 2x3 Factorial ANOVA procedure involves the investigation of the interaction effects of two or more independent variables. The statistical procedure used is ANOVA which tests for group mean differences.

This technique is being used to answer the question; Are father and mother scores significantly different from each other on each of the twelve variables, regardless of group membership? Two independent variables, parent sex and family group (clinical-incest group versus clinical non-incest group versus non-clinical group), were examined in relation to each separate dependent variable (personality, sexuality, family of origin/perceived health, eight family structure variables, & adaptation/adjustment).

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The Scheffe is a post hoc comparison technique commonly used to judge all contrasts in the analysis of variance. It has been used in this study after the 2x3 Anova to take a closer look at what the specific significant differences.

The Oneway ANOVA procedure is used to test the statistical significance of the difference among means. Twleve separate ANOVA's were run to answer the question of whether father and mother difference scores were significantly different across each of the three groups. For each couple their scores were subtracted from each other and a resulting difference score analyzed.

Chapter IV

Results

Eighty cases were used in the analysis. No missing data was noted, and no outliers threatened the analysis. The assumptions of linearity, normality, singularity, and homogeneity of variance were met for discriminate analysis and ANOVA. All twelve variables are described (mean, standard deviation, and range) in table 5.

Table 5. Variable Description for Combined Groups (N=80)

Variable	Mean	Standard Deviation	Possible Range	Observed Range
Sexuality	217.86	36.35	73 to 292	179 to 248
Family of Origin	149.49	18.6	40 to 200	120 to 193
Personality	1.05	5.06	-12 to 12	-10 to 10
Adaptation/ Adjustment	86.27	26.43	8 to 163	34 to 149
Father-Child Cohesion/ Estrangement	29.13	5.80	10 to 40	16 to 40
Mother-Child Cohesion/ Estrangement	22.57	6.73	9 to 36	9 to 36

Table 5. continued...

Family Conflict Avoided/ Expressed	21.36	5.19	8 to 32	10 to 31
Spouse Conflict Resolved/ Unresolved	25.13	10.67	10 to 40	13 to 40
Family Enmeshment/ Disengage	33.26	6.46	11 to 44	19 to 44
Cross-Generational Triad	31.30	6.09	11 to 44	16 to 44
Parental Overprotect/ Autonomy	25.67	6.79	9 to 36	16 to 36
Family Flexiblity/ Rigidity	25.13	5.57	9 to 36	11 to 34

The Discriminate Function Analysis procedure was used in this study to determine what combination of twelve variables; adaptation/adjustment, personality, sexuality, family of origin perceived health, father-child cohesion/estrangement, mother-child cohesion/estrangement, cross-generational triads, resolved/unresolved spouse conflict, expressed/avoided family conflict, family flexibility/rigidity, family enmeshment/disengagement, and parental overprotection/autonomy best predicts group membership in the clinical incest, clinical non-incest, and non-clinical groups.

Two types of discriminant function analysis were used; (1) Direct Entry, and (2) Stepwise. In the Direct

Entry procedure all of the predictor variables enter the equation at once. The primary reason for use of this procedure is theoretical, to look at the unique contribution each variable has to total variation. In the Stepwise procedure the set of predictors are ordered based upon their statistical ability to discriminate among groups. This procedure has a more pragmatic rationale in determining assessment criteria.

The 2x3 Factorial ANOVA procedure examines two independent variables, parent sex and family group (clinical incest group versus clinical non-incest group versus non-clinical group), in relation to each of the twelve separate dependent variables (adaptation/ adjustment, personality, sexuality, family of origin perceived health, father-child cohesion/ estrangement, mother-child cohesion/estrangement, cross-generational triads, resolved/unresolved spouse conflict, expressed/avoided family conflict, family flexiblity/ rigidity, family enmeshment/disengagement, and parental overprotection/autonomy.

A Direct Entry Discriminant Function Analysis was performed initially using twelve variables as predictors of membership in three groups. Two discriminant functions were calculated with a combined chi-square of 73.995, probability less than .01. After removal of the first function there was very little discriminating power. Chi-Square was equal to 8.4243 and was not significant at the .05 alpha level. Function one accounted for ninety-one

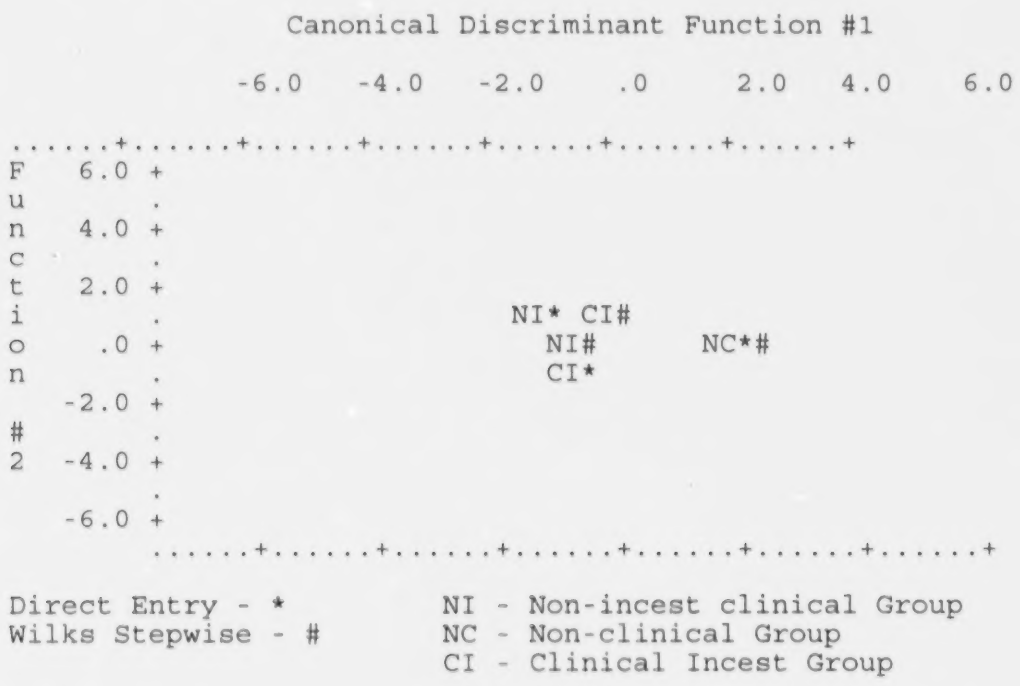
percent of the between-group variability and maximally separated between groups (figure C). Sixty-six percent of grouped cases were correctly classified (table B).

Six variables with correlations above .35 are listed in order of their size of correlation within the first function (table A); (1) Cross-generational Triad (r=.76), (2) Adaptation/ Adjustment (r=.60), (3) Family Conflict (r=.50), (4) Father-child Cohesion/Estrangement (r=.44), (5) Enmeshment/ Disengagement (.42), and (6) Overprotection/Autonomy (r=.42). The importance of each independent variable to discrimination among the groups was evaluated by examining the correlation of each independent variable with the participants' scores on the first discriminant function. A correlation of .35 or above was considered to indicate substantive importance since at least 12% of the variance in the independent variable is shared with the discriminant function score. The Wilks Stepwise Discriminant Function was also run with little difference from the direct entry. The Wilks Stepwise Procedure will be reported. This procedure selects the variable that best minimizes the Wilk's Lambda statistic for maximum discriminating power. The Wilk's Lambda statistic is the ratio of within-groups variance to total variance.

The Wilks Stepwise Procedure calculated two discriminate functions with a combined Chi-square of 67.472. After removal of the first function there was little discriminating power; 5.548. Function one

accounted for ninety-four percent of the between-group variability and maximally separated between groups (figure C). Sixty-eight percent of the grouped cases were correctly classified (table B).

Six variables with discriminating power above .4 were listed in order of their size of correlation within the first function (table A); (1) Cross-generational Triad, (2) Adaptation/Adjustment, (3) Enmeshment/Disengagement, (4) Family Conflict, (5) Overprotection/Autonomy, and (6) Father-child Cohesion/Estrangement.



In both the Direct Entry and the Wilks procedures, the greatest discrimination among groups occurs in function #1. Function #1 discriminates especially well between the non-clinical group and the other two.

Figure 4. All-Groups Plot of Group Centroids

Table 6. Classification Summary

DIRECT ENTRY*

Actual Group	#Cases	Predicted CI	Predicted NI	Predicted NC
CI	28	19 67.9%	6 21.4%	3 10.7%
NI	22	10 45.5%	11 50.0%	1 4.5%
NC	30	6 20.0%	1 3.3%	23 76.7%

* Sixty-six percent of grouped cases were correctly classified.

WILKS STEPWISE**

CI	28	20 71.4%	4 14.3%	4 14.3%
NI	22	10 45.5%	12 54.5%	0 0.0%
NC	30	6 20.0%	2 6.7%	22 73.3%

** Sixty-eight percent of grouped cases were correctly classified.

Table 7. Discriminating Variables Ordered by Their Size of Correlation within the Function

Predictor Variable	Group Mean	Correlation Function #1
Cross-Generational Triad	CI 29.50 NI 26.95 NC 36.17	DIRECT .76 WILKS .79
Adaptation Adjustment	CI 76.18 NI 73.45 NC 105.10	DIRECT .60 WILKS .63
Family Conflict avoid/express	CI 19.93 NI 20.00 NC 24.07	DIRECT .50 WILKS .52
Father-Child Cohesion/ Estrangement	CI 27.11 NI 27.23 NC 32.40	DIRECT .44 WILKS .38
Enmeshment/ Disengagement	CI 31.57 NI 30.68 NC 36.73	DIRECT .42 WILKS .54
Overprotect/ Autonomy	CI 23.54 NI 23.36 NC 29.37	DIRECT .42 WILKS .42
Personality	CI 2.66 NI 1.09 NC -.47	DIRECT -.12 WILKS -.12
Sexuality	CI 214.39 NI 220.77 NC 218.96	DIRECT .01 WILKS -.08
Mother-Child Cohesion/ Estrangement	CI 22.79 NI 25.27 NC 20.41	DIRECT -.26 WILKS -.27

Table 7. continued...

Predictor Variable	Group Mean		Correlation Function #1
Spouse Conflict Resolved/ Unresolved	CI	24.68	DIRECT .06
	NI	24.45	WILKS .20
	NC	26.03	
Flexibility/ Rigidity	CI	25.43	DIRECT -.01
	NI	24.86	WILKS -.00
	NC	25.03	
Family of Origin	CI	148.64	DIRECT .12
	NI	146.59	WILKS .15
	NC	152.40	
Canonical R			DIRECT .74
			WILKS .73
Eigenvalue			DIRECT .12
			WILKS 1.12

For the 2 x 3 Factorial Anova (group by sex), the questions being asked are: (1) Are father and mother scores significantly different from each other regardless of group membership?, (2) Are group scores significantly different?, and (3) Is here an interaction between group and sex? Father and mother scores were compared with each other on each of the twelve variables.

Significance values are noted for group and sex main effects in tables 7 & 8.

One group by sex interaction effect was significant for the sexuality variable ($p<.046$). However, further analysis using the conservative post hoc Scheffe procedure

resulted in no significance ($p<.202$) at the .05 alpha level.

Table 8. Results of the Factorial ANOVA - Group Effects

Variable	Group Mean	Significance Value Group Main Effects
Family of Origin	CI 148.64 NI 146.59 NC 152.40	.529
Personality	CI 2.66 NI 1.09 NC -.47	.163
Sexuality	CI 214.39 NI 220.77 NC 218.96	.805
Enmeshment/ Disengagement*	CI 31.57 NI 30.68 NC 36.73	.001
Cross-Generational Triad*	CI 29.50 NI 26.95 NC 36.17	.000
Father-Child Cohesion/ Estrangement*	CI 27.11 NI 27.23 NC 32.40	.000
Mother-Child Cohesion/ Estrangement*	CI 22.79 NI 25.27 NC 20.41	.036
Family Conflict*	CI 19.93 NI 20.00 NC 24.07	.000

Table 8. continued...

Variable	Group Mean	Significance Value Group Main Effects
Flexibility/ Rigidity	CI 25.43 NI 24.86 NC 25.03	.936
Overprotect/ Autonomy*	CI 23.54 NI 23.36 NC 29.37	.000
Spouse Conflict	CI 24.68 NI 24.45 NC 26.03	.835
Adaptation/ Adjustment*	CI 76.18 NI 73.45 NC 105.10	.000

* Denotes a significance level lower than a .05 probability.

Table 9. Results of the Factorial ANOVA - Sex Main Effects

Variable	Means Male	Means Female	Significance Value Sex Main Effects
Family of Origin	149.10	149.87	.855
Personality	.35	1.75	.778
Sexuality	215.25	220.47	.516
Enmeshment/ Disengagement	32.63	33.90	.343
Cross-Generational Triad	30.40	32.20	.089
Father-Child Cohesion/ Estrangement	28.65	29.60	.430
Mother-Child Cohesion/ Estrangement	22.32	22.82	.736
Family Conflict	20.65	21.85	.670
Flexibility/ Rigidity	25.60	24.65	.460
Overprotect/ Autonomy	24.88	26.47	.250
Spouse Conflict*	22.38	27.88	.022
Adaptation/ Adjustment	86.65	86.90	.805

* Denotes a significance level lower than a .05 probability

As can be seen in table 7, seven variables showed significant differences among groups. A conservative Post Hoc test (Scheffe) was then performed upon the remaining eight variables that had significant values in the Factorial ANOVA results. The purpose being to determine where the differences were and if they were truly significant under more rigorous analyses.

To determine the actual difference in the sex main effect, the mean score values were noted for fathers and mothers for the Spouse Conflict variable. The mean score values for fathers across groups was 22.38, and for mothers it was 27.88. The lower score is interpreted as perceiving greater unresolved conflict with one's spouse. The scoring range is 40 to 10. Thus fathers were significantly different from mothers.

Table 10. Scheffe Results

Variable	Group Means CI	NI	NC	Significance Value at a .05 Probability
Sexuality	x	x	x	not significant
Enmeshment/ Disengagement	x	x	x	not significant
Cross-Generational Triad	29.5	26.9	36.2	.0000
Father-Child Cohesion/ Estrangement	27.1	27.2	32.4	.0003

Table 10. continued...

Variable	Group Means CI	NI	NC	Significance Value at a .05 Probability
Mother-Child Cohesion/ Estrangement	22.8	25.3	20.4	.0365
Family Conflict	19.9	20.0	34.1	.0000
Overprotect/ Autonomy	23.5	23.4	29.4	.0004
Adaptation/ Autonomy	76.2	73.5	105.1	.0001

The significant group pairs consisted of NC with NI and NC with CI. Mother-Child Cohesion/Estrangement was the only exception with the significant group pair being NI with NC.

CI - Clinical-Incest Group
NI - Non-Incest Clinical Group
NC - Non-Clinical Group

For the Oneway ANOVA procedure, difference scores were calculated between each couple and an ANOVA run for each of the twelve variables to determine significant differences across the three groups. The question being asked is: Are father and mother difference scores significantly different across groups? There were no significant differences at the .05 probability level for any of the twelve variables.

The following report will present findings sequentially in order of the hypotheses.

Hypothesis 1: Relative to non-incestuous families, incestuous families will be characterized by more fathers being identified in the extroversion grouping as measured by the Eysenck.

There was no significant discrimination among the three groups as measured by the Eysenck. The Direct Entry coefficient for this variable was -.12 (function #1). For Wilks it was .12 (function #1).

Hypothesis 2: Relative to non-incestuous families, incestuous families will be characterized by significantly lower adaptation and adjustment scores as measured by the FIRA-G.

The clinical-incest group was discriminated from the non-clinical group by lower adaptation/adjustment scores (table A). Lower scores are interpreted as less adaptivity. There was no discrimination between the clinical-incest and non-incest clinical groups on this variable.

Hypothesis 3: Relative to non-incestuous families, incestuous families will be characterized by significantly lower father scores on the HCSQ.

There was no significant discrimination among the three groups as measured by the HCSQ. The Direct Entry

coefficient for this variable was .01 (function #1). For Wilks it was -.08 (function #1).

Hypothesis 4: Relative to non-incestuous families, incestuous families will be characterized by significantly lower father scores on the Family of Origin Scale.

There was no significant discrimination among the three groups on father's responses to the Family of Origin Scale. The Direct Entry coefficient for this variable was .12 (function #1). For Wilks it was .15 (function #1).

Hypothesis 5: Relative to non-incestuous families, incestuous families will be characterized by greater enmeshment of their families as measured by the SFIS-R.

The clinical incest group was discriminated from the non-clinical group by lower enmeshment/disengagement scores (table A). Lower scores are interpreted as higher disengagement. This was in the opposite direction than predicted. There was no discrimination between the clinical incest and non-incest clinical groups on this variable.

Hypothesis 6: Relative to non-incestuous families, incestuous families will be characterized by parental overprotection of the children.

The clinical incest group was discriminated from the non-clinical group by lower overprotection/autonomy scores (table A). Lower scores are interpreted as higher

autonomy. This was in the opposite direction than predicted. The range of scoring is 36 to 9. There was no discrimination between the clinical incest and non-incest groups on this variable.

Hypothesis 7: Relative to non-incestuous families, incestuous families will be characterized by a greater rigidity of family rules and roles.

There was no significant discrimination among the three groups on this variable. The Direct Entry coefficient for this variable was -.01 (function #1). For Wilks it was -.002 (function #1).

Hypothesis 8: Relative to non-incestuous families, incestuous families will be characterized by greater father-child cohesion.

The clinical-incest group was discriminated from the non-clinical group by lower father-child cohesion/ estrangement scores (table A). Lower scores are interpreted as higher father-child estrangement. This was in the opposite direction than predicted. The range of scoring is 40 to 10. There was no discrimination between the clinical-incest and non-incest clinical groups.

Hypothesis 9: Relative to non-incestuous families, incestuous families will be characterized by greater avoidance of family conflict.

The clinical-incest group was discriminated from the non-clinical group by lower family conflict avoidance/expression scores (table A). Lower scores are interpreted as higher family conflict expression. this was in the opposite direction than predicted. The range of scoring is 32 to 8. There was no discrimination between the clinical incest and non-incest clinical groups.

Hypothesis 10: Relative to non-incestuous families, incestuous families will be characterized by greater unresolved spouse conflict.

There was no significant discrimination among the three groups on this variable. The Direct Entry coefficient for this variable was .06 (function #1). For the Wilks procedure it was .20 (function #1).

Hypothesis 11: Relative to non-incestuous families, incestuous families will be characterized by more cross-generational triads.

The clinical-incest group was discriminated from the non-clinical group by lower cross-generational triad scores. Lower scores are interpreted as more cross-generational triads. This was in the predicted direction. The non-incest clinical group was discriminated by having the lowest score of both groups.

Hypothesis 12: Relative to non-incestuous families, incestuous families will be characterized by greater mother-child estrangement.

There was no significant discrimination among the three groups on this variable. The Direct Entry coefficient for this variable was -.26 (function#1). For Wilks it was -.27 (function #1).

Chapter V

Summary, Discussion, and Recommendations

Summary and Discussion

Each hypothesis will be restated with a brief summary.

Hypothesis 1: Relative to non-incestuous families, incestuous families will be characterized by more fathers being identified in the extroversion grouping as measured by the Eysenck.

The Eysenck scores did not have any discriminating power between the three groups in discriminate function analysis. The father and mother scores did not show any significant differences from each other regardless of group membership (2x3 ANOVA).

The Oneway ANOVA also showed no significant value for mother and father difference scores across each of the three groups. For this hypothesis there was no difference in the Eysenck scores of fathers across each of the three groups.

Only this aspect of personality has been ruled out. More exploratory investigations should be done with other aspects of personality using such measures as the Myers Briggs Personality Measure, The California Personality Inventory, and the Sixteen Personality Factor Measure.

For the integrative model proposed in this study, Offender personality factors do not include extroversion or neuroticism.

Hypothesis 2: Relative to non-incestuous families, incestuous families will be characterized by significantly lower adaptation and adjustment scores as measured by the FIRA-G.

The adaptation/adjustment scores did discriminate well between the non-clinical group and the two other clinical groups, but did not show significant differences between the clinical-incest and non-incest clinical groups (Discriminant Function). There were no significant differences between father and mother scores regardless of or across each of the three groups (2x3 ANOVA, & Oneway ANOVA).

For this hypothesis the incestuous families scores were significantly different from the non-clinical but not the non-incest clinical group.

As expected, clinical families do not adjust and adapt to changes and/or stressor pile-up as well as non-clinical families. This is significant information for the treatment of any clinical family in helping them stabilize any changes occurring through therapy.

This supports the vulnerability model proposed by Trepper & Barrett noting the inability of incest families when adapting to stressor pile-up. For the integrative model proposed in this study, clinical incest families were distinguishable from non-clinical families by their lower adaptation and adjustment but not the clinical non-incest group. Lower adaptation and adjustment appears to be a factor in clinical families including those where

incest occurs. It is not distinguishable from other types of family dysfunction.

Hypothesis 3: Relative to non-incestuous families, incestuous families will be characterized by significantly lower father scores on the HCSQ.

The HCSQ scores did not have any discriminating power between the three groups in the discriminant function analysis. The father and mother scores did not show any significant differences from eachother regardless of group membership (2x3 ANOVA). The Oneway ANOVA showed no significant values for mother and father difference scores across each of the three groups.

For this hypothesis there was no difference in HCSQ scores (perceived sexual adjustment) of fathers across each of the groups. The results are therefore limited by this particular measure and inconclusive.

Hypothesis 4: Relative to non-incestuous families, incestuous families will be characterized by significantly lower father scores on the Family of Origin Scale.

The Family of Origin Scores did not have any discriminating power between the three groups in the discriminant function analysis. The father and mother scores did not show any significant differences from each other regardless of group membership (2x3 ANOVA). The Oneway ANOVA also showed no significant values for the mother and father difference scores across groups.

For this hypothesis there was no difference between the Family of Origin scores of fathers across each of the three groups.

Self-esteem is a construct defined and measured in many ways. For this integrative model, it has been defined as an artifact of the perceived health of an individual's family of origin. It's lack of significance refers only to this particular way of definition and measurement. Low self-esteem of incestuous fathers is so often referred to in the literature that further investigation is warranted by other interpretive ways of measurement.

Hypothesis 5: Relative to non-incestuous families, incestuous families will be characterized by greater enmeshment of their families as measure by the SFIS-R.

The enmeshment/disengagement scores did discriminate well between the non-clinical group and the two clinical groups, but in an opposite direction than predicted. The clinical-incest and non-incest clinical scores were lower than the non-clinical scores noting higher disengagement.

Since there were no norms for the SFIS-R scale, it must be presumed that the non-clinical group was not at an extreme enmeshed position but that the two clinical groups were more disengaged.

There were no significant differences in the 2x3 ANOVA, or Oneway ANOVA. For this hypothesis the incestuous families scores were significantly different

from the non-clinical group but not the non-incest group. The difference was greater disengagement in the clinical-incest and non-incest clinical families than in the non-clinical families.

This aspect was significant but in an unexpected direction, and only between clinical and non-clinical families. The measurement was focused upon interpretations of enmeshment and disengagement that may be different from those of previous explanatory models. The assumption was made that if incestuous families were more isolated from those outside of their families, and individual boundaries were not maintained and/or acknowledged, then enmeshment would be prevalent.

In this analysis, disengagement was higher in incest and non-incest clinical families than non-clinical. This may be referring to dysfunctional communication and relationship skills inherent in many clinical families as well as incest families.

Hypothesis 6: Relative to non-incestuous families, incestuous families will be characterized by parental overprotection of the children.

The overprotection/autonomy scores did discriminate well between the two clinical groups and the non-clinical group, but in the opposite direction than predicted. The clinical-incest and non-incest clinical group scores were lower than the non-clinical group noting higher autonomy (2x3 ANOVA & Scheffe).

. . . .

Since there were no norms for the SFIS-R scale, it must be presumed that the non-clinical group was not at an extreme position but that the two clinical groups reported parent-child relationships as being more autonomous. There were no significant differences found in the Oneway ANOVA. For this hypothesis the incestuous families scores were significantly different from the non-clinical families scores but not the non-incest clinical families. The difference was greater autonomy in the parent-child relationships of the clinical-incest and non-incest clinical groups but not the non-clinical group.

This aspect of family structure was significant but in an unexpected direction and only between clinical and non-clinical populations.

The assumption in this study was that parental overprotection would be high based upon the overcontrolling role of father purported in the social-structural, victim-perpetrator, and freudian models.

What appears to have been measured were disengaged (hypothesis 5) relationships that exist in many dysfunctional families as a result of poor communication and relationship skills. This accounts for the discrimination between clinical and non-clinical groups.

Hypothesis 7: Relative to non-incestuous families, incestuous families will be characterized by a greater rigidity of family rules and roles.

The flexibility/rigidity scores did not have any

discriminating power between the three groups in the discriminant function analysis. The father and mother scores did not show any significant differences from eachother regardless of group membership (2x3 ANOVA)

The Oneway ANOVA also showed no significant values for mother and father difference scores across groups.

For this hypothesis there was no difference in the flexibility/rigidity scores for families across each of the three groups.

This aspect of family structure was not significant. The social-structural and vulnerability models along with previous literature for father-daughter molest explanation have referred to the inability of the family to be flexible. This is reportedly due to authoritarian rule by the father and/or a family's adaptation and adjustment inabilities.

What appears to have been measured is consistent with hypotheses 2, 5, and 6. Many dysfunctional families are more disengaged in their relationships resulting in greater inability to communicate with and support its members for adaptation to stress and change. Higher flexibility in clinical groups may not refer to better adaptability and communication but to a greater disconnectedness in family relationships.

Hypothesis 8: Relative to non-incestuous families, incestuous families will be characterized by greater father-child cohesion.

The father-child cohesion/estrangement scores did discriminate well between the two clinical groups and the non-clinical group but in an opposite direction than predicted. The clinical-incest and non-incest clinical group scores were lower than the non-clinical group noting higher father-child estrangement (2x3 ANOVA). No norms for this scale require an interpretation of non-clinical scores as not extreme and the two clinical group's father-child relationships as more estranged.

For this hypothesis the incestuous father's scores were significantly different from the non-clinical father's scores but not the non-incest clinical. The difference was higher father-child estrangement in the clinical-incest and non-incest clinical groups than the non-clinical group.

This aspect of family structure supports the social-structural model noting higher father-child estrangement in clinical incest groups. For this study a higher cohesion was expected based upon mother-child role-reversal and poor boundary maintenance. As a result, the father and child were expected to form a close relationship. What may have been measured was an emotional, not physical distance. A father that lacks empathy and objectifies the child, with the father using her to fulfill his own needs without regard for hers.

Hypothesis 9: Relative to non-incestuous families, the incestuous families will be characterized by greater avoidance of family conflict.

The family conflict expressed/avoided scores did discriminate well between the two groups and the non-clinical group but in an opposite direction than predicted. The clinical-incest and non-incest clinical group scores were lower than the non-clinical group noting higher
expression of family conflict (2x3 ANOVA). There were no significant differences in the Oneway ANOVA.

For this hypothesis the incestuous families scores were significantly different from the non-clinical group but not the non-incest clinical group. The difference was that clinical-incest and non-incest clinical families expressed more family conflict than the non-clinical group.

This aspect of family structure refers to family conflict that is expressed and not avoided. For this study avoided conflicts were expected. The difference may lie in how "avoided" is being defined.

Whether expressed or unexpressed, nothing was concluded about how. Conflict that is openly discussed with reason is different from conflict expressed in anger and without resolution.

What can be interpreted from this result is that clinical families express more conflict than non-clinical families. In light of what has been inferred from

previous hypotheses about clinical family communication, this higher conflict expression does not enhance more functional family interaction.

Hypothesis 10: Relative to non-incestuous families, incestuous families will be characterized by greater unresolved spouse conflict.

The spouse conflict resolved/unresolved scores did not have any discriminating power between the three groups in the discrminant function analysis. The father and mother scores did not show any significant differences from eachother regardless of group membership (2x3 ANOVA).

The Oneway ANOVA showed no significant value for mother and father difference scores across the three groups.

For this hypothesis there was no significant difference in the spouse conflict scores for couples across groups.

This aspect of family structure, unresolved spouse conflict, has been supported by previous literature and the social-structural model to be a significant part of incest families. For the purpose of this study and previous explanations, spouse conflict resolution was not a factor in incest families.

What may be happening here in this analysis is a difference in what has been measured. Resolution is not the same as how one goes about resolving or attempting to

resolve conflict (hypothesis 9). Whether or not conflicts are resolved does not distinguish between groups.

Hypothesis 11: Relative to non-incestuous families, incestuous families will be characterized by more cross-generational triads.

The cross-generational triad scores did discriminate well between the two clinical groups and the non-clinical group. The clinical-incest and non-incest clinical group scores were significantly lower than the non-clinical group noting the presence of more cross-generational triads (2x3 ANOVA, Scheffe).

The Oneway ANOVA showed no significant values for mother and father scores across groups.

For this hypothesis the incestuous families scores were significantly different from the non-clinical but not the non-incest clinical group. Fathers in the incestuous families group perceived more cross-generational triads in their families than did mothers in the same group.

This family structure variable supports the poor boundary maintenance that was anticipated in this study's integrative model. Much of the previous literature notes the alliance that occurs between father and child for incest families. The variable does not discriminate between incest and non-incest clinical groups. It does join the functional/dysfunctional family discrimination package of variables that has been assembled so far in this study. Dysfunctional families appear to have more

inappropriate adult-child relationships than functional families. An explanation may lie in dysfunctional family relationship inadequacy where children are expected to meet adult needs and adults assume child roles.

Hypothesis 12: Relative to non-incestuous families, incestuous families will be characterized by greater mother-child estrangement.

The mother-child cohesion/estrangement scores did not have any discriminating power across the three groups in the discriminant function analysis.

The father and mother scores did prove to be significantly different from eachother across groups (2x3 ANOVA & Scheffe). The difference was between the non-clinical and non-incest groups with the non-clinical group scores being lower. These lower scores are interpreted as greater mother-child estrangement, opposite from prediction.

There were no significant differences in the Oneway ANOVA. For this hypothesis there was no difference in the mother child cohesion/estrangement scores between incestuous and non-incestuous families.

The discriminant function analysis was not significant but the 2x3 factorial ANOVA was. It is possible that the contribution of mother-child cohesion/estrangement is washed-out in the context of the other variables.

For this study the expected estrangement between

mother and child was a complementary "fit" with father-child cohesion and unresolved spouse conflict. the assumption being that higher unresolved spouse conflict was associated with a poor relationship between mother and father. Father would then choose daughter (cross-generational triad) as a substitute spouse and mother would be distanced from both. Mother-child estrangement and spouse conflict were not factors in incest family dynamics and father-child estrangement was.

This supports the social-structural and victim-perpetrator model by placing less emphasis on the mother placing more responsibility on father for the molest.

Table 11. The Analysis Summary

Variable	Analysis	Results
Family of Origin	1. D.F.A. 2. 2x3 ANOVA & Scheffe 3. Oneway ANOVA	No significant result on any test.
Personality	1. D.F.A. 2. 2x3 ANOVA & Scheffe 3. Oneway ANOVA	No significant result on any test.
Sexuality	1. D.F.A. 2. 2x3 ANOVA & Scheffe 3. Oneway ANOVA	No significant result No significant result No significant result
Cross-Generational Triad	1. D.F.A. 2. 2x3 ANOVA & Scheffe 3. Oneway ANOVA	Good discrimination between the two clinical groups and the non-clinical. The CI & NI scores were lower than the NC noting a higher perception of CGT. No significant result
Father-Child Cohesion/ Estrangement	1. D.F.A 2. 2x3 ANOVA & Sceheffe 3. Oneway ANOVA	Good discrimination between the two clinical groups and the non-clinical. The CI & NI group scores were lower than NC noting higher estrangement. No significant result

Table 11. continued...

Variables	Analysis	Results
Mother-Child Cohesion/ Estrangement	1. D.F.A.	No significant result
	2. 2x3 ANOVA & Scheffe	NC group scores were lower than NI, noting greater estrangement.
	3. Oneway ANOVA	No significant result
Family Conflict Expressed/ Avoided	1. D.F.A.	Good discrimination between the two clinical groups and NC.
	2. 2x3 ANOVA & Scheffe	The CI & NI scores were lower than NC, noting higher expression of conflict.
	3. Oneway ANOVA	No significant result
Flexibility/ Rigidity	1. D.F.A.	No significant result
	2. 2x3 ANOVA & Scheffe	on any test.
	3. Oneway ANOVA	
Overprotect/ Autonomy	1. D.F.A.	Good discrimination between the two clinical groups and NC.
	2. 2x3 ANOVA & Scheffe	The CI & NI scores were lower than NC, noting higher autonomy.
	3. Oneway ANOVA	No significant result
Spouse Conflict	1. D.F.A.	No significant result
	2. 2x3 ANOVA & Scheffe	No significant result
	3. Oneway ANOVA	No significant result
Adaptation/ Adjustment	1. D.F.A.	Good discrimination between the two clinical groups and NC.
	2. 2x3 ANOVA & Scheffe	No significant result
	3. Oneway ANOVA	No significant result

Table 11. continued...

Variables	Analysis	Results
Enmeshment/ Disengaged clinical groups and NC.	1. D.F.A.	Good discrimination between the two
	2. 2x3 ANOVA & Scheffe	No significant result
	3. Oneway ANOVA	No significant result

Table 12. The Hypotheses Summary Table

Hypothesis #	Result
1	This measure of personality not significantly different between incest and non-incest fathers.
2	Incestuous families were significantly different from non-clinical but not non-incest clinical by lower adaptation/adjustment.
3	This measure of sexuality was not significantly different between incest and non-incest fathers.
4	This measure of Family of Origin perceived health was not significantly different between incest and non-incest fathers.
5	Incestuous families were significantly different from non-clinical but not non-incest clinical by higher family disengagement.
6	Incestuous families were significantly different from non-clinical but not from non-incest clinical by higher parent-child autonomy.
7	This measure of family rigidity was not significantly different between incest and non-incest families.

Table 12. continued...

Hypothesis #	Result
8	Incestuous families were significantly different from non-clinical but not non-incest clinical by higher father-child estrangement.
9	Incestuous families were significantly different from non-clinical but not from non-incest clinical by higher expression of family conflict.
10	This measure of unresolved spouse conflict was not significantly different between incest and non-incest families.
11	Incestuous families were significantly different from non-clinical but not from non-incest clinical by more cross-generational triads.
12	This measure of mother-child estrangement was not significantly different between incest and non-incest families.

In sum this analysis has noted that compared to the NC (non-clinical) group, the CI (clinical-incest) & NI (non-incest clinical) groups have significantly higher cross-generational triads, significantly higher father-child estrangement, significantly more expression of family conflict, and significantly higher parent-child autonomy as noted by both the discriminant function analysis and 2x3 ANOVA. The discriminant function alone resulted in significantly higher family disengagement, and significantly lower adaptation and adjustment for the clinical compared to the non-clinical group. The 2x3

ANOVA alone showed greater mother-child estrangement in the clinical groups. Table 12 summarizes the final conclusions for hypotheses in this study.

My initial impression from these results is a description of a clinical family not exclusively incestuous. Individual members appear distant and disconnected from one another (father-child estrangement, family disengagement, parent-child autonomy, & mother-child estrangement). Their connection with each other is necessary for the supportiveness required in families that adapt well to stressor pile-up. Adaptation/adjustment was lower in clinical families affirming this lack of connectedness.

As is typical in families that appear to lack connectedness among its members, children will often move inappropriately into an adult role by default. This results in the children parenting themselves and their own parent(s). This is due to a lack of access or connectedness with appropriate adults (Giaretto, 1976). Higher cross-generational triads were noted in the clinic groups, affirming this confusion over roles and boundaries between child and adult.

Family conflict was expressed more in the clinical groups and may be due to a lack of conflict resolution inherent in this disconnectedness as well.

Some variables identified in the literature on father-daughter incest as important to its understanding and treatment, were not statistically significant; father

personality, father sexuality, spouse conflict, and father self-esteem.

This is one possible picture portrayed by the results of this study of a clinical family compared to a non-clinical family. The study, however began as an attempt to test a model of multi-factored explanation in the discrimination of incestuous families from clinical non-incest and non-clinical families. The primary focus in this discussion is that there were no significant differences between the clinical-incest group and the clinical non-incest group.

Limitations of this Study

One possible explanation for the lack of significant differences between the two clinical groups is that they are not different but the same on the twelve variables tested. The overlap between groups of variables common to varying degrees and types of family dysfunction is a limitation of this study. Variables such as spouse conflict, family conflict, adaptation/adjustment, and family enmeshment/disengagement all exist in some degree, in most families. Identifying the right degree and combination of variables that will assist in assessment and treatment of incest is the challenge.

Another possible limitation in the interpretation of the results of this study is problems with measurement. Many of the measures used were initially designed to note differences between clinical and non-clinical families and

may not be sensitive enough to identify differences among various clinical groups.

The variables may have been the wrong choice. The question; Are these the right variables to discriminate? is still a valid one. The literature from which the variables were collected and upon which the hypotheses were based was derived from clinical incest families and may not be true for incest families in general.

Any study is limited which relies too heavily upon one type of measure of a phenomena. Self-report in this study has limited the findings to the perceptions and not the actual behaviors of the families involved. Though there is value in knowing this perceptual reality, it is equally important to make comparisons by observing behavior and obtaining qualitative interviews.

Social desirability may have also played a part in limiting the interpretations of the results of this study. The clinical incest families were obtained before any therapy intervention. They were obtained atter they had been identified by the legal system which may have created a very high mistrust and defensiveness. This may have resulted in an attempt to look good with the self-report measures.

The sample was comparable on several important factors for all three groups. There were two sampling differences among the three groups, however which warrant attention. The ages of husbands and wives in the non-clinical incest group were significantly lower ($p<.05$) in

a oneway ANOVA statistical analysis comparing the three groups (table 1). This difference may have influenced the perceptions of the clinical non-incest group in such a way that their self-report responses made their group incomparable.

Marital status (table 1) may have contributed also to group sample differences. The non-clinical group couples were all currently married. The two clinical groups both had a currently separated couple status of 14% for clinical incest and 18% non-incest clinical. Seven percent were currently divorced in the clinical incest group. The differences are small and both clinical groups appear to be comparable. Divorce and separation are expected differences in clinical families compared to non-clinical families. Certainly the comparability of the two clinical groups has strengthened confidence in the finding that both groups are difficult to discriminate from eachother.

It is possible that there were other variables present and not known or accounted for that would have made the groups significantly different from each other and not comparable. It is also possible that this particular sample is not representative of the greater population of which it is a part due to non-random sampling. The most paralyzing of all limitations in the study of the father-daughter incest phenomenon may very well be the inability to screen comparison groups to insure that father-daughter incest is not taking place.

Without this careful screening possible, we can never make a true comparison without some overlap.

Theoretical Significance of the Discriminant Function Analysis Although the discriminant function analysis classification results reported in table 6 are not sufficient for clinical assessment, they may have important theoretical significance. In the direct entry and stepwise procedures a relatively high percentage of clinical incest cases were correctly classified.

It is also interesting to note that 20% of the non-clinical group were predicted incorrectly to be in the clinical-incest group. This is consistent with the prevalence literature that 1 in 5 females are victims of incest. The non-incest group was poorly classified with 45.5% predicted incorrectly into the clinical-incest group, and 50% predicted correctly. The twelve variables were unable to discriminate in some combination among the clinical non-incest cases.

Correct prediction for the clinical-incest group was sizeable (67.9% direct entry & 71.4% stepwise). This in contrast to the poorly classified non-incest group leads to the conclusion that something is happening that does in fact discriminate between the two clinical groups. There were differences between discriminant function, 2x3 ANOVA, and oneway ANOVA results (table 11) that are due to how variable contributions to total variation are analyzed. The oneway ANOVA examines the unique contribution of a variable individually. The 2x3 ANOVA also analyzes the

individual contributions of each variable separately only with multiple levels of the dependent variable. The discrminant function analysis is different in that it looks at contributions of linear combinations of variables to total variation.

It appears quite clear that a combination of variables was able to capture more of what was going on in the clinical incest group by evidence of this high prediction percentage. The proposal of a multi-causal model for explaining father-daughter incest has been supported. The correct prediction of clinical-incest families from among other types of families is dependent upon combinations of variables. Individual variables are not sensitive enough to discriminate among the overlap that exists between clinical-incest and clinical non-incest groups.

The HCSQ is still being developed and refined. Because of this, the results pertaining to sexuality are tentative. Father-daughter molest involves sexuality as well as many other factors. It is warranted to suggest that study continue in this area with some other more developed measure and/or after continued refinement of the HCSQ. My suggestion is that any look at sexuality should involve past and present orientation and experience.

Contributions of this Study

This study makes contributions in the area of father-daughter incest on several levels. First of all it assembles together the most common explanation offered for this phenomena over several years and across several disciplines. Typically these explanations have stood alone as partial attempts to explain this multi-factored problem. Admittedly it would have been an easier task to investigate only a portion of the complexities of father-daughter incest. Certainly not even the partial explanations have received any rigorous investigation over the years. In spite of there being several separate and popular explanations, there has been very little attempted to test them with sizeable samples and comparison groups. This study (N=80) compares three groups and tests twelve variables representative of popular explanations that at times have even contradicted each other.

It is important to note that comparison groups of non-clinical samples have gotten little attention in the study of father-daughter incest. I must underscore the requirement in the future to include comparison groups from clinical non-incest and non-clinical populations. This study has shown clearly that had I not used the clinical non-incest group for comparison, my results would have been interpreted quite incorrectly with false assumptions not only about assessment but also treatment.

The results have challenged what has been reported for many years in some of the literature and poses some

possible conclusions; Incest families can be identified apart from other clinical families. Clinical-incest groups and clinical non-incest groups are alike in many ways. Father-daughter incest is a multi-factored problem that no single theory or variable can accurately explain. Multi-factored combinations are needed to capture a more complete picture of the phenomenon.

The incest taboo and our discomfort with father-daughter incest may be the driving force behind desperate attempts to believe that only father offenders can be identified and their behaviors predicted. This limited scope of understanding fails to acknowledge the complexity of father-daughter incest.

This study proposes an integrative model that is guided theoretically and defined by specific variables that can be operationalized and developed toward a more comprehensive assessment and treatment of father-daughter incest.

Recommendations for Further Research

There is a need for further testing of this or some type of integrative model that subsumes the many partial explanations that exist. We don't need more explanations, we need to test the ones that we have and determine their validity since many have already become accepted standards for treatment in many facilities.

This area of study appears to be stuck on issues of prevalence. Though it is important (and far simpler) to

attempt to count just how much incest is "out there", I am concerned that not enough attempts are being made to understand father-daughter incest. Understanding how and why will lead to more successful treatment and eventually prevention, reducing how much is "out there".

Clarification of variables and research that involves multi-vantage points and multiple perspectives is a very important next step. This can be accomplished with the use of different types of measurement along with self-report, and by obtaining the perceptions of the victim, siblings, extended family members, and therapists.

There are many factors currently offered up in incest explanation. It is important to make them as testable as possible and then to test with the widest variety of perspectives to offer the most comprehensive picture possible. No one perspective is more accurate than another. All perceptions are biased interpretations of an unobtainable reality.

The challenge of obtaining a clinical-incest population before contact with the legal system is a big one. One possible way to obtain this sample would be in a longitudinal study of several families. The families would be measured and would also sign a release allowing the researcher to contact the child welfare system at any time for the next ten years. After checking with the welfare and legal systems, incest families could be identified and compared.

After an integrative foundation of understanding has

been developed and tested, the next step would be to ask researchable questions that ask which treatment is the most effective.

Father-daughter incest has been with us for centuries, and it appears that societal taboos have only been effective in limiting research, not incest. My hope is that with this study there will be a new direction. A direction toward consideration of all of the possible pieces to this "puzzle". Not just the ones that fit ideologies or comfort levels. Father-daughter incest is a complex problem that will not be ignored by myopic fears, political loyalties, or inadequate research designs.

Father-daughter incest is a complex multi-factored problem. This study has affirmed the need to use multi-factored combinations of variables to explain and study the phenomenon. The use of different statistical techniques has shown the importance of linear combinations of variables over individual variables in increasing their sensitivity to discriminate. An initial foundation of a variable combination has been discovered as a beginning to the building process at hand using a multi-causal model of explanation.

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APPENDICES

Appendix A

The Therapist Form

THERAPIST FORM

I am currently a doctoral student in Marriage and Family Therapy at Purdue University in West Lafayette, Indiana. I hold a Master's degree in educational psychology and have had eight years of experience treating abusive, emotional, and behaviorally disturbed children and families in community mental health and private settings.

My dissertation research is on the family dynamics of father-daughter incest. There are many causal explanations for father-daughter incest; my research is an attempt to integrate these into a comprehensible and measurable model.

I need your help in administering the Core Assessment and Treatment Evaluation (C.A.T.E.) packet to: (1) families where father-daughter incest has occurred at some time during the past year and they have not received treatment as yet, (2) families where there have been no incestuous occurrences; however, they are involved in treatment for some other reason, and (3) families that have had no involvement with treatment and are not involved in treatment for any reason.

My parameters are: (a) couples between ages 22 and 45 who have lived together over the last year in the same household with at least one daughter between the ages of five and eighteen years old. They should not have received any more than six sessions of therapy before being tested.

The packet is to be administered to both parents in all three groups. It takes approximately forty-five minutes. A code number is selected from the list of codes enclosed, assigned, and written on each page. When you send the completed material to me, all identifying information will be removed except for the assigned codes. All attempts will be made to keep this information confidential. A list identifying codes and names will be kept in a separate place from where the main data is stored to insure this.

INSTRUCTIONS FOR ADMINISTRATION OF C.A.T.E.:

1. Read the Consent Form to both parents. Allow them to read it and ask questions. Ask them both to sign it and then you witness and date it.

2. Give a copy of the Demographic Information Form to both parents.

3. At this point you may begin to complete the Family Information Form.

4. The FIIS-R Form A is next for completion by both parents. It is the only form that requires the answers to be written on a separate IBM answer sheet. Please ensure that the ovals are completely darkened and completed in pencil.

5. The Eysenck Short Questionnaire is to be completed next by both parents.

6. The Family of Origin Scale follows and is also to be completed by both parents.

7. The following seven short scales are to be given to both parents at this time: Family Stressors, Family Strains, Relative and Friend Support, Social Support Index, Family Coping-Coherence, Family Hardiness Index, and Family Distress.

8. The last scale to be completed by both parents is the Heterosexual Couples Questionnaire.

9. Make sure that all questions have been answered, and all sheets have an I.D. CODE #.

10. Call me at the number below for any questions you may have or to obtain additional forms.

11. I will pick up all completed forms personally.

Thank you and your families for your participation in this research project. My hope is that it will not only better our understanding of incest but also our assessment and treatment.

Appendix B

The Consent Form

CONSENT FORM

Research is a way everyone may gain greater knowledge and understanding of a particular problem. This study is focused upon families and the variety of ways they relate to one another. All types of families are being included, some with and some without current problems.

Your permission is sought in order to use information obtained from your response to the pencil and paper questionnaire packet identified by the initials: C.A.T.E. Your identity will be kept entirely anonymous and the information treated confidentially.

Your participation is voluntary. Some of you may currently be receiving therapy services at a clinic.* If you decide not to participate in this study or cease participation once you have begun, your treatment and its quality will not be affected.

This study is not a part of the Purdue Marriage and Family Therapy clinic or any other treatment facility.

I understand that my name, address, and any other identifying information will NOT be made public and will NOT be used for any other purpose. I give permission to use scores and the information obtained from the questionnaires in dissertation research being conducted by William E. Utesch.

YES _____ NO _____

_____ _____
signature date

_____ _____
signature date

_____ _____
witness date

* I give my permission for my therapist to provide demographic information about our family to be used in this research with the same conditions of anonymity and confidentiality mentioned above.

YES _____ NO _____

_____ _____
signature date

_____ _____
signature date

_____ _____
signature date

** Results will be presented to you upon request.

Appendix C

Demographic Information

DEMOGRAPHIC INFORMATION

I.D. CODE # _____

Name _____

Ethnic Group: White _____
Black _____
Asian _____
American Indian _____
Spanish Origin _____
Other _____

Age at last birthday _____

Your Present Occupation: (please be specific, e.g., telephone linesman, not telephone company) _____
_____

Your annual income:
_____Below $10,000
_____Above $10,000 & Below $19,999
_____Above $20,000 & Below $29,999
_____Above $30,000 & Below $39,999
_____Above $40,000 & Below $49,999
_____Above $50,000

Marital Status:
Never married _____
Currently married _____
Currently separated _____
Currently divorced _____
Currently widowed _____
Living together _____

Years together with current partner: _____

Your Education:
_____Some grade school
_____Completed grade school
_____Some high school
_____Completed high school
_____Some college
_____Completed college
_____Some graduate school
_____Completed graduate school
_____Special training program(s)

Degree _____ Field _____

Degree _____ Field _____

Field _____

List everyone that lived together in your household for most of the last year and their relationship to you:

Name	D.O.B.	Male	Female	Natural	Step	Non-family

Appendix D

The Family Information Form

Family Information Form (to be completed by the therapist). The following is information related to the father-daughter molest of family:

I.D. CODE # _____

1. How was the incest discovered?
   _____ Daughter reported
   _____ Father reported
   _____ Mother discovered
   _____ Other family member discovered
   _____ Other (describe) _____

2. What happened when it was discovered?
   _____ Nothing
   _____ Reported
   _____ Separation of parents
   _____ Placement of daughter outside of home
   _____ Removal of father from the home
   _____ Therapy began
   _____ Other (describe) _____

3. _____ How old was daughter when the incest began?

4. _____ How long did it continue?

Please check the appropriate blank(s):

_____ 1. Rape, forcible genital intercourse
_____ 2. Nonforcible genital intercourse
_____ 3. Attempted rape
_____ 4. Nonforcible attempted genital intercourse
_____ 5. Forcible felatio, cunnilingus, analingus, anal intercourse
_____ 6. Nonforcible felatio, cunnilingus, analingus, anal intercourse
_____ 7. Forcible attempted felatio, cunnilingus, analingus, anal intercourse
_____ 8. Nonforcible attempted falatio, cunnilingus, analingus, anal intercourse
_____ 9. Forcible genital contact (unclothed) including manual touching or penetration
_____ 10. Nonforcible genital contact (unclothed) including manual touching or penetration
_____ 11. Forcible attempted genital contact (unclothed) including manual touching or penetration
_____ 12. Nonforcible attempted genital contact (unclothed) including manual touching or penetration
_____ 13. Forcible breast contact (unclothed) or simulated intercourse
_____ 14. Nonforcible breast contact (unclothed) or simulated intercourse
_____ 15. Forcible attempted breast contact (unclothed) or simulated intercourse
_____ 16. Nonforcible attempted breast contact (unclothed) or simulated intercourse
_____ 17. Forcible sexual kissing, intentional sexual touching of buttocks, thigh, leg, or clothed breasts or genitals
_____ 18. Nonforcible sexual kissing, intentional sexual touching of buttocks, leg, clothed breasts or genitals